

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

3855

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Bethesda</u> LENGTH OF STAY (In this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u> (If rural, give location) STREET ADDRESS <u>30 E. Bradley Lane</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>			
3. NAME OF DECEASED (Type or Print)	(First) <u>Catherine</u>	(Middle) <u>Marie</u>	(Last) <u>Abbott</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>30</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 1, 1876</u>
9. AGE last birthday <u>74</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Ireland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	13. FATHER'S NAME <u>Costello</u>	14. MOTHER'S MAIDEN NAME <u>Gorman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Ira H. Abbott 30 E. Bradley Ln.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause <u>(a) Acute Myocardial Failure with Pulmonary Edema</u> 3 days.</p> <p>260X Antecedent cause(s) <u>(b) Diabetes Mellitus, Severe</u> 25 yrs.</p> <p>61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(c) Hypertensive Cardio-Vascular-Renal Disease</u> 15 yrs.</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Cholecystitis</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>May</u> , 1948, to <u>April 30, 1951</u> , that I last saw the deceased alive on <u>29 April</u> , 1951, and that death occurred at <u>7:30 A.m.</u> , from the causes and on the date stated above. SIGNATURE <u>Stewart Blaft</u> (Degree or title) <u>M.D.</u> ADDRESS <u>3921 Ingoney St. with 20 4-30-51</u> DATE SIGNED <u>11. Cu.</u>			
23. BURIAL, CREMATION REMOVAL (Specify) Burial-transit	DATE THEREOF <u>May 1, 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Pinehill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Wolfeboro, N. Hampshire</u>
DATE REC'D BY LOCAL REG. <u>4/30/51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

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MAY 2 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3856

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY MONTGOMERY			2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN OLNEY, MD.			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN OLNEY, MD.		
HOSPITAL OR INSTITUTION OR MONTG. COUNTY GENERAL HOSPITAL STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) ALLAN	(Middle) MCCLANE	(Last) ABERT	4. DATE OF DEATH APRIL 7	(Month) (Day) 5 (Year) 1951
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE	8. DATE OF BIRTH MARCH 27, 1865	9. AGE last birthday 86	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk & S. Bache			10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES ABERT			14. MOTHER'S MAIDEN NAME HENRIETTA BACHE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS HOSPITAL RECORD	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Uremia					
Immediate cause (a) 610X					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 137a					
Urinary retention					
Conditions contributing to the death but not related to the disease or condition causing death. (c) Prostatic hypertrophy simple					
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar 26, 1951, to April 7, 1951, that I last saw the deceased alive on April 7, 1951, and that death occurred at 11:20 a.m., from the causes and on the date stated above. SIGNATURE M.B. (Degree or title) ADDRESS Sandy Rd. DATE SIGNED 4/9/51					
23. BURIAL, CREMATION MOV. (Specify) Burial		DATE THEREOF April 9, 1951		NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery	LOCATION (City, town, or county) Rockville, Md. (State)
DATE REC'D BY LOCAL REG. 4-9-51		REGISTRAR'S SIGNATURE Rockville Lawyer		24. FUNERAL DIRECTOR Warren E. Gumpfshay Silver Spring, Md. ADDRESS 390916	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A157

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APR 12 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3857

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place) Bethesda 22 yrs		2. USUAL RESIDENCE (HOME) OF DECEASED STATE COUNTY Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda STREET ADDRESS 4901 Edgewood Lane	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4901 Edgewood Lane					
3. NAME OF DECEASED (Type or Print) Eugene		(First) (Middle) G. (Last) Adams		4. DATE OF DEATH Apr 7 1951	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insistence Agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance		8. DATE OF BIRTH 7 Jul 1886	
11. BIRTHPLACE (State or foreign country) Danville, Va.		9. AGE last birthday 64 yr		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen Edward Adams		14. MOTHER'S MAIDEN NAME Bonnie Dinguid		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 579-42-8363		17. INFORMANT AND ADDRESS Mrs. Eugene G. Adams Bethesda, Md.		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) *Coronary occlusion*  
 94a Antecedent cause(s)  
 Disease or conditions, if any, (b) giving rise to the above cause  
 stating the underlying cause last (c)

INTERVAL BETWEEN  
ONSET AND DEATH*Found dead on  
bath room  
floor.*

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.20. AUTOPSY?  
Yes  No 

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OCCURRED While at work	Not while at work	HOW DID INJURY OCCUR?	
m.						

22. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes  accident  suicide  homicide  undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Cremation		DATE THEREOF 9 Apr 1951	NAME OF CEMETERY OR CREMATORIAL Cemetery	LOCATION (City, town, or county) Baltimore	(State) Maryland
DATE REC'D BY LOCAL REG.	REG. 4-13-51		REGISTRAR'S SIGNATURE Helen S. Eckenfelder	24. FUNERAL DIRECTOR Robert A. Lumphrey	ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.  
is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

3858

Reg. Dist. No. 2/8

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and OR give nearest town)		2. USUAL RESIDENCE (HOME) OF DECEASED CITY (If outside corporate limits, write RURAL and give nearest town)	
Montgomery Maryland		Maryland	
TOWN Leytonsville		TOWN Leytonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Yover Davis Armstrong		(Month) ap (Year) 1951	
(Middle)		(Day) 11	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED		8. DATE OF BIRTH Oct 30-1901	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President G. B. Armstrong Co. Int'l. Oil Midland Va		11. BIRTHPLACE (State or foreign country) Midland Va	
13. FATHER'S NAME LeBANOV B. ARMSTRONG		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT AND ADDRESS Esther Murphy Armstrong	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Coronary occlusion			
Antecedent cause(s) (b) 4/20/1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) sudden death.			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH. INJURY		PLACE (Home, farm, factory, street, (CITY OR TOWN) (COUNTY) (STATE) of office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE Frank J. Brochart M.D.		ADDRESS Gaithersburg Md	
DATE SIGNED 4-11-51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF April 14-1951	
DATE REC'D BY LOCAL REG. 4/13/51		NAME OF CEMETERY OR CREMATORIAL Loytonville	
REG. 4/13/51		LOCATION (City, town, or county) Montgomery Co. Md	
REG. 4/13/51		(State)	
REG. 4/13/51		REGISTRAR'S SIGNATURE	
REG. 4/13/51		24. FUNERAL DIRECTOR Loyola Hospital	
REG. 4/13/51		ADDRESS Loytonville	
REG. 4/13/51		290618	

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PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A1



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3854

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Pa.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Coleridge</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pittsburgh</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Jolliffe Nursing Home</i>		STREET ADDRESS <i>(If rural give location)</i>	

3. NAME OF DECEASED (Type or Print)	(First) <i>Ella</i>	(Middle) <i>Mary</i>	(Last) <i>Bahra</i>	4. DATE OF DEATH <i>April 16</i>	(Month) <i>1951</i>	(Day) <i>1951</i>	(Year)
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Feb 10, 1863</i>	9. AGE last birthday yrs. <i>89</i>	10. If under 1 year Months <i>0</i>	11. If under 24 hrs. Days <i>0</i>	12. If under 24 hrs. Hours <i>0</i>	13. If under Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Bakerstown, Pa.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>James Ross</i>	14. MOTHER'S MAIDEN NAME <i>Charlotte Pearce</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>No</i>	17. INFORMANT AND ADDRESS <i>Mrs. W.E. Branthover</i>
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18. MEDICAL CERTIFICATION		
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I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
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157X Immediate cause <i>Carcerous of heel of foot</i>	(a) <i>8 mm.</i>
46g Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <i>None</i>
	(c) <i>None</i>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<i>Local Carbuncle decompositio</i>	<i>8 mm.</i>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
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21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from <i>Aug. 5, 1950</i> to <i>April 13, 1951</i> , that I last saw the deceased alive on <i>April 13, 1951</i> , and that death occurred at <i>2:19 p.m.</i> from the causes and on the date stated above.				
SIGNATURE <i>John. Ross M.D.</i>	(Degree or title) <i>Physician</i>	ADDRESS <i>1007 Seminary Rd. 44-15-51</i>	DATE SIGNED <i>April 13, 1951</i>	

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <i>4/17/51</i>	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
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DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>Frances Potter</i>	24. FUNERAL DIRECTOR	ADDRESS
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april 17/51		<i>The S.H. Nines Co. 2901-145</i>	<i>Wash., D.C. 20001</i>
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APR 19 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3860

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <i>Mary</i>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Virginia</i>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Bethesda</i>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Arlington</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>5612 Wisconsin Ave</i>			STREET ADDRESS <i>4025 S. 9th St.</i>		
3. NAME OF DECEASED (Type or Print) <i>Abigail Jackson Barnum</i>			4. DATE OF DEATH <i>Aug 23 1951</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i>	8. DATE OF BIRTH <i>Oct 10, 1868</i>	9. AGE last birthday <i>82</i>	If under 1 year Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>computer - self-employed co.</i>			11. BIRTHPLACE (State or foreign country) <i>Ill.</i>		
13. FATHER'S NAME <i>Miles J. Barnum</i>			14. MOTHER'S MAIDEN NAME <i>A. M. Gill</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>123-45-6789</i>		
17. INFORMANT AND ADDRESS <i>Mrs Ethel Knoblock</i>					

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) *Acute cardiac dilatation*

3 hr

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last(b) *carcinoma of liver*

3 yrs

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
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22. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes  accident  suicide  homicide  undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

4-23-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <i>4/23/51</i>	NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, county) <i>Columbia Cemetery Arlington Va</i>	(State)
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DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>Frances Miller</i>	24. FUNERAL DIRECTOR ADDRESS <i>Cherry Grove Board Home, 5103 7th St. N.W.</i>
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April 23 1951		510246 m.t.
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RECEIVED  
APR 25 1951  
BUREAU, U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

3861

1. PLACE OF DEATH COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY: <i>Pr. 110.</i>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Bethesda</i>			LENGTH OF STAY (in this place) <i>7 years</i>		
TOWN <i>Towers</i>			CITY (If outside corporate limits, write RURAL and give nearest town) OR <i>Cowndale</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburbia Capital 8600 Old Georgetown Rd.</i>			TOWN <i>Washington 18</i>		
STREET ADDRESS <i>4904 Russell Ave.</i>			STREET <i>(If rural, give location)</i>		
3. NAME OF DECEASED (Type or Print) <i>Benjamin Ward</i>		(First) <i>B</i> (Middle) <i>enjamin</i> (Last) <i>Ward</i>	4. DATE OF DEATH <i>4-8-51</i>		(Month) <i>4</i> (Day) <i>8</i> (Year) <i>1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Divorced</i>	8. DATE OF BIRTH <i>1-18-66</i>	9. AGE last birthday yrs. <i>8</i>	If under 1 year Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>England</i>	12. CITIZEN OF WHAT COUNTRY? <i>England</i>
13. FATHER'S NAME <i>Benjamin Ward</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS		
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

903.0 Immediate cause	(a) <i>Toxemia</i>	6 wks
1860 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <i>Chronic nephritis</i>	5 yrs
1860 (c) <i>Fractured left femur</i>	<i>Wide spread cystic bone disease</i>	2-16-51
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <i>2-16-51</i>	19b. MAJOR FINDINGS OF OPERATION <i>None</i>	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE <i>acc.</i>	(Specify) <i>work</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>None</i>	(CITY OR TOWN) <i>Cowndale</i>	(COUNTY) <i>Prince George</i>	(STATE) <i>and</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2-16-51</i>	INJURY <i>m.</i>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <i>Fell while walking on level floor</i>		

22. I hereby certify that I attended the deceased from *2-16-51* to *4-8-51*, 19....., that I last saw the deceased alive on *4-7-51*, 19....., and that death occurred at *4:20 A.M.* from the causes and on the date stated above.  
SIGNATURE *John O'Rollen* (Degree or title) *MD* ADDRESS *7930 Georgia Ave Silver Spring MD* DATE SIGNED *4-8-51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Glenswood</i>	DATE THEREOF <i>4/10/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Glenswood</i>	LOCATION (City, town, or county) <i>DC</i>	(State) <i>DC</i>
DATE REC'D BY LOCAL REG. <i>4-8-51</i>	REGISTRAR'S SIGNATURE <i>Helen Kurys</i>	24. FUNERAL DIRECTOR ADDRESS <i>John H. Nichols Co. 2901 14th St N.W. Washington D.C.</i>		

RECEIVED

APR 12 1961

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3862

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

I. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE District of Columbia	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS 3010 Woodland Drive, N.W.	
3. NAME OF DECEASED (Type or Print)	(First) Paul	(Middle) Henry	(Last) BASTEDO
4. DATE OF DEATH April 18, 1951	(Month) April	(Day) 18	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH Feb 25, 1887
9. AGE last birthday 64 yrs.	If under 1 year Months 01	If under 24 hrs. Days 24	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Walter B. BASTEDO		14. MOTHER'S MAIDEN NAME Catherine A. HENRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW I-II	
17. INFORMANT AND ADDRESS Wife: Helen P. BASTEDO		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause (a) <i>Anemia</i> 154X Antecedent cause(s) (b) <i>Intercourse to both parties</i> 46d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>From Chronic Rectum</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?  DATE SIGNED
22. I hereby certify that I attended the deceased from Mar 6, 1951, to Apr 18, 1951, that I last saw the deceased alive on Apr 18, 1951, and that death occurred at 5:53 A.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
T. N. QUILTER, Jr., MC, USN		U. S. NAVAL HOSPITAL April 18, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Apr 20, 1951	NAME OF CEMETERY OR CREMATORIAL Arlington National
DATE REC'D BY LOCAL REG Apr 18, 1951		REGISTRAR'S SIGNATURE <i>Edie Whittington</i>	LOCATION (City, town, or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR ADDRESS S. H. Hines, 2901 14th Street, NW, Washington, D. C. W.R.W. J-29096			

RECEIVED

APR 20 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3863

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

<b>1. PLACE OF DEATH</b> COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda</u> LENGTH OF STAY (in this place) <u>5 hours</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u> STREET ADDRESS <u>4912 Hampden Lane</u> (If rural, give location)			
<b>3. NAME OF DECEASED</b> (First) <u>Mary</u> (Middle) <u>Lillian</u> (Last) <u>Bauskett</u> (Type or Print)				<b>4. DATE OF DEATH</b> <u>4 - 10 - 1951</u>		<b>(Month)</b> <u>4</u> <b>(Day)</b> <u>10</u> <b>(Year)</b> <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-14-1874</u>	9. AGE last birthday 76 yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cath. Charities</u>	11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>John Bauskett</u>		14. MOTHER'S MAIDEN NAME <u>Helen J. Niernsee</u>		17. INFORMANT AND ADDRESS <u>Katherine Calhoun - 4912 Hampden Lane</u> (SISTER)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Sp. Am. War</u>		16. SOCIAL SECURITY NO.		18. MEDICAL CERTIFICATION <u>Cerebrovascular Hemorrhage</u> <span style="float: right;">2 yrs</span>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> Immediate cause <u>Cerebrovascular Hemorrhage</u> Antecedent cause(s) <u>Hypertensive Cerebrovascular Disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>chronic peptic ulcer</u> (a) <u>443X</u> (b) <u>117a</u> (c)							
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <u>chronic peptic ulcer</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE <u>—</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>—</u>		(CITY OR TOWN) <u>—</u>		(COUNTY) <u>—</u> (STATE) <u>—</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>46</u> , to <u>4/10</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>51</u> , and that death occurred at <u>11:45</u> a.m., from the causes and on the date stated above. SIGNATURE <u>J. L. Marks, M.D.</u> ADDRESS <u>6306 Wisconsin Ave Chevy Chase, Md</u> DATE SIGNED <u>4/10/51</u>							
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/13/51</u>		NAME OF CEMETERY OR CREMATORIAL <u>Washington National</u>		LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State) <u>—</u>	
DATE REC'D BY LOCAL REG. <u>4-11-51</u>		REGISTRAR'S SIGNATURE <u>Helen J. Eickendorf</u>		24. FUNERAL DIRECTOR <u>Robert A. Bumby</u>		ADDRESS <u>Cherry Chase, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1964

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3864

Items 8, 9 on:

ITEM NO. G 132 MAY 14 1951

2411 N. Charles Street, Baltimore

Reg. Dist. No. 22

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

COUNTY

Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL and LENGTH OF STAY

OR give nearest town)

TOWN

Length of stay (in this place)

HOSPITAL OR

INSTITUTION OR

STREET ADDRESS

2. NAME OF

DECEASED

(Type or Print)

(First)

(Middle)

(Last)

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED,

(Specify)

Married

8. DATE OF BIRTH

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1951  
MIREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3865

## CERTIFICATE OF DEATH

215

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>TOWN Bethesda, Rural</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Glen Burnie, Marley Park</b>	
LENGTH OF STAY (This place) <b>5 1/2 mos.</b>		STREET (If rural, give location) <b>Box 14, Greenway Rd.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U.S. Naval Hospital</b>		ADDRESS	
3. NAME OF DECEASED (Type or Print) <b>Roland</b>		(First) <b>Roland</b> (Middle) <b>James</b> (Last) <b>BONNEVILLE</b>	
6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	
5. SEX <b>Male</b>		8. DATE OF BIRTH <b>July 21, 1926</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Petty Officer</b>		9. AGE last birthday If under 1 year Months <b>24</b> Day <b>09</b> Hours <b>04</b> Min. <b>51</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>	
13. FATHER'S NAME <b>Raymond J. BONNEVILLE</b>		14. MOTHER'S MAIDEN NAME <b>Olive HOWEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT AND ADDRESS <b>Uncle: Robert L. BONNEVILLE</b>		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <b>Uremia</b>			
7571 Antecedent cause(s) (b) <b>chronic glomerulonephritis</b> 2 years			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>congenital Polycystic Disease of Kidneys</b> life			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg, etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 10, 1950, to Apr 25, 1951, that I last saw the deceased alive on Apr 25, 1951, and that death occurred at 3:53 P.m., from the causes and on the date stated above. SIGNATURE <i>F. B. Rogers</i> (Degree or title) ADDRESS DATE SIGNED			
F. B. ROGERS, LT JG, MCR, USNR U.S. NAVAL HOSPITAL April 26, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Apr 28, 1951</b> NAME OF CEMETERY OR CREMATORIAL <b>Glen Haven Memorial</b> LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>Apr 26, 1951</b>		REGISTRAR'S SIGNATURE <i>Elie Whittington</i> 24. FUNERAL DIRECTOR ADDRESS <i>Wastler Funeral Home, 301 East Capitol Street, Washington, D.C.</i>	

STANDARD SURVEYING INSTRUMENTS  
AND RELATED EQUIPMENT  
STANDARD SURVEYING

RECEIVED  
APR 27 1951  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

3866

1. PLACE OF DEATH. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MARYLAND</u>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>		
LENGTH OF STAY (in this place) <u>18 years</u>		STREET ADDRESS <u>8201 Schrier Street, apt. #6</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8201 Schrier Street, apt. #6</u>		(If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) <u>DANIEL</u>	(Middle) <u>W.</u>	(Last) <u>BOWIE</u>	
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>3</u>	(Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 17, 1897</u>	
9. AGE last birthday If under 1 year Months <u>53</u> yrs. <u>53</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Canning Business Owner</u>	11b. KIND OF BUSINESS OR INDUSTRY <u>Cannings</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel W. Bowie</u>	14. MOTHER'S Maiden NAME <u>Minnie Russell</u>	15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>WWI</u>	
17. INFORMANT AND ADDRESS <u>Mildred F. Bowie (wife) 8201 Schrier St. S.E. Md.</u>	18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
154X Immediate cause <u>Carcinomatosis Generalized</u>	(a) <u>Carcinoma of Rectum</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>46 d</u>	(b) <u>Carcinoma of Rectum</u>	5 yrs		
(c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?		
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
10/8/1949 4/3/1951	11/30/1951	1951		
22. I hereby certify that I attended the deceased from <u>10/8/1949</u> to <u>4/3/1951</u> , that I last saw the deceased alive on <u>4/3/1951</u> , and that death occurred at <u>11/30/1951</u> m., from the causes and on the date stated above.				
SIGNATURE <u>Frances Teller</u>		ADDRESS <u>5801-13 42 St NW</u>	DATE SIGNED <u>4/3/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 6, 1951</u>	NAME OF CEMETERY OR CREMATORIY <u>Arlington National Cemetery</u>	LOCATION (City, town, or county) <u>Arlington</u>	(State) <u>Virginia</u>
DATE REC'D BY LOCAL REG. <u>Apr 4, 1951</u>	REGISTRAR'S SIGNATURE <u>Frances Teller</u>	24. FUNERAL DIRECTOR ADDRESS <u>Arthur Walters, 254 Carroll St. NW. D.C.</u>		



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3867

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY Alexandria		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda, Rural LENGTH OF STAY (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Alexandria STREET ADDRESS 107 East Raymond Avenue (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital			4. DATE (Month) (Day) (Year) OF DEATH April 22, 1951		
3. NAME OF DECEASED (First) Benjamin (Middle) Franklin (Last) BROOKS			5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist			10b. KIND OF BUSINESS OR INDUSTRY US Gov't		
11. BIRTHPLACE (State or foreign country) Washington			12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Benjamin BROOKS			14. MOTHER'S MAIDEN NAME Emma AULT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. W W		
17. INFORMANT AND ADDRESS Wife: Pansy M. BROOKS			18. MEDICAL CERTIFICATION Same as item # 2		

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) CARCINOMA, RECTUM

INTERVAL BETWEEN  
ONSET AND DEATH  
10 mos.

## 154X Antecedent cause(s)

Diseases or conditions, if any, (b) giving rise to the above cause  
stating the underlying cause last

46d (c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED OF INJURY m.	While at Work <input type="checkbox"/>	Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 2, 1951, to Apr 22, 1951, that I last saw the deceased  
alive on Apr 22, 1951, and that death occurred at 8:15 P.m., from the causes and on the date stated above.  
SIGNATURE *H. A. Graves, Jr.* (Degree or title) ADDRESS DATE SIGNED

H. A. GRAVES, Jr., LTJG, MCR, USNR U.S. NAVAL HOSPITAL April 23, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF Apr 23, 1951	NAME OF CEMETERY OR CREMATORIAL Tacoma Cemetery	LOCATION (City, town, or county) Tacoma, Washington	(State)
DATE REC'D BY LOCAL REG. Apr 23, 1951	REGISTRAR'S SIGNATURE <i>Edwin Whittington</i>	24. FUNERAL DIRECTOR W. W. Chambers, 3072 M Street, NW, Washington, D.C.	ADDRESS	

RECEIVED  
APR 24 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3868

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Pennsylvania	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McKeesport	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		COUNTY Allegheny	
STREET ADDRESS 1121 Washington Street		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) Frank		4. DATE OF DEATH April 27, 1951	
5. SEX Male		5. COLOR OR RACE White	
6. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		7. 10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		8. DATE OF BIRTH Dec 1, 1902	
12. CITIZEN OF WHAT COUNTRY? US		9. AGE last birthday 48 yrs.	
13. FATHER'S NAME Thomas BUCHANAN		14. MOTHER'S MAIDEN NAME Mary CAMPBELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Wife: Vera Daerr BUCHANAN		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 581X		(a) Bleeding esophageal varices	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause 1246 - stating the underlying cause last		(b) Cirrhosis of the liver	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 25 April 51		19b. MAJOR FINDINGS OF OPERATION Cirrhosis of the liver	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar 18, 1951, to Apr 27, 1951, that I last saw the deceased alive on Apr 27, 1951, and that death occurred at 9:02 P.m., from the causes and on the date stated above. SIGNATURE Paul TRAUTMAN DATE SIGNED April 28, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF Apr 28, 1951	
DATE REC'D BY LOCAL REG. Apr 28, 1951		NAME OF CEMETERY OR CREMATORIAL McKeesport, Pennsylvania	
REGISTRATION NUMBER 1055819		LOCATION (City, town, or county) ADDRESS	
24. FUNERAL DIRECTOR Robert A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.			
REGISTRATION NUMBER 1055819			

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SEARCHED  INDEXED  SERIALIZED  FILED

1

APR 2 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3869

216

Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS <u>134 Maple Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Thomas</u>	(Middle) <u>H</u>	(Last) <u>Burriss</u>
4. DATE OF DEATH <u>April 24 1951</u>	(Month)	(Day)	(Year)
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-18-87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping night Clerk.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Work</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>Thomas</u>	14. MOTHER'S MAIDEN NAME <u>Mary A. Gray</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>578-03-5241</u>		17. INFORMANT AND ADDRESS <u>Helen M. Burriss 134 Maple Ave. Kensington</u>	18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) Diabetic coma & shock & anuria

?

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) Adenocarcinoma of bladder

2 years

## 51b

(c) Carcinoma of prostate

2 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

None

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE

## (Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

INJURY

TIME (Month) (Day) (Year) (Hour)

(CITY OR TOWN)

INJURY OCCURRED  
OF  
INJURY

(CITY OR TOWN)

While at Work

How did injury occur?

Not While At work

m.

At work

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3870

Reg. Dist. No. 216

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Bethesda		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5625 Oak Place		STREET ADDRESS (If rural, give location) 5625 Oak Place	
3. NAME OF DECEASED (Type or Print) Ellen	(First) (Middle) Elizabeth	(Last) Carpenter	4. DATE OF DEATH April 18 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 5 Nov 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 71 yrs.
13. FATHER'S NAME Michael Brady		11. BIRTHPLACE (State or foreign country) New Jersey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Mrs. Edwin C. Estes Bethesda, Maryland		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Intestinal obstruction - cause undetermined

INTERVAL BETWEEN  
ONSET AND DEATH

1 week

## Antecedent cause(s)

420.0 Diseases or conditions, if any, giving rise to the above cause  
93d stating the underlying cause last

(b)

Hypertension  
Arteriosclerotic heart disease

6 years

3 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day)	(Year)	INJURY OCCURRED While at m. Work	Not While At work	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/8, 1951, to 4/18, 1951, that I last saw the deceased alive on 4/16, 1951, and that death occurred at 2:30 a.m., from the causes and on the date stated above.  
 SIGNATURE *David Benjamin Ward* ADDRESS *4700 Block 10th Bethesda Md 418157* DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Transit-Burial	DATE 19 April 1951	NAME OF CEMETERY OR CREMATORIAL St. Peters	LOCATION (City, town, or county) Belleville, New Jersey
DATE REC'D BY LOCAL REG.	REG. 4-20-51	REGISTRAR'S SIGNATURE <i>Helen J. Eberle</i>	FUNERAL DIRECTOR ADDRESS <i>Robert G. Humphrey Bethesda, Md.</i>

740 - Standard Phony



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Olney		LENGTH OF STAY (in this place) 4 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brookeville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County General Hospital, Inc.		STREET ADDRESS				(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) George	(Middle) Franklin	(Last) Cashell	4. DATE OF DEATH April 28 1951	(Month) April	(Day) 28	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M.	8. DATE OF BIRTH 3/13/77	9. AGE last birthday 74 yrs.	If under 1 year Months	If under 1 year Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY On Farm	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME George W. Cashell		14. MOTHER'S MAIDEN NAME Katherine Hobbs					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT AND ADDRESS Hospital records				
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause 446X		(a) _____	Uremia		INTERVAL BETWEEN ONSET AND DEATH 1 month		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a		(b) _____	Nephrosclerosis		5 years		
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		(Specify) INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)		(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 6, 1948</u> to <u>April 28, 1951</u> , that I last saw the deceased alive on <u>April 27, 1951</u> , and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Charles S. Whitaker, M.D.</u> ADDRESS <u>Clarksville, Md.</u> DATE SIGNED <u>4/28/51</u>							
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF April 30, 1951		NAME OF CEMETERY OR CREMATORIAL Mt. Carmel		LOCATION (City, town, or county) Montgomery County	
DATE REC'D BY LOCAL REG. 4-30-51		REGISTRAR'S SIGNATURE Esther B. Lawler		24. FUNERAL DIRECTOR Ray W. Barber		(State) ADDRESS 100405	

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BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3872

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY		
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR		
TOWN		15 days		TOWN		W <small>ASHING</small> T <small>ON</small>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Cedar Haven Rest Home		STREET		(If rural, give location)		
ADDRESS		1325 Euclid St. N.W.		ADDRESS		1325 Euclid St. N.W.		
3. NAME OF DECEASED (Type or Print)		(First) Hattie	(Middle) Lamb	(Last) Castens	4. DATE OF DEATH	(Month) April	(Day) 17	(Year) 1951
5. SEX Female		6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 12/3/1867	9. AGE last birthday 83 yrs.	If under 1 year Months	If under 24 hrs. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY	4.5.A.		
Housewife		Home		MOTHER'S MAIDEN NAME Margaret C. Wright				
13. FATHER'S NAME Lyman H. Lamb		14. SOCIAL SECURITY NO. None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. INFORMANT AND ADDRESS Mrs. H. D. Cooper, 1220 Jefferson St., N.W.		

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause 903.0				(a) Gastro-intestinal hemorrhage, etiology not determined				30 hrs.	
Antecedent cause(s) 166.0				(b) Hypertension				Years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last				(c) Arterio-sclerotic heart disease				Years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				Senility				Years	
19a. DATE OF OPERATION 1-31-51		19b. MAJOR FINDINGS OF OPERATION Open reduction, nailing rt. h. fracture		PLACE (Home, farm, factory, street, of office bldg., etc.)		(CITY OR TOWN) Washington		(COUNTY) (STATE) D.C.	
21. ACCIDENT / SUICIDE HOMICIDE		(Specify) Accident		INJURY		HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year)		(Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		Slipped and fell in bathroom.			
OF INJURY Jan. 26, 1951		38th.							

22. I hereby certify that I attended the deceased from April 11, 1951, to April 17, 1951, that I last saw the deceased alive on April 17, 1951, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

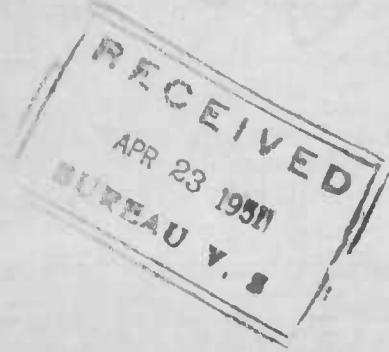
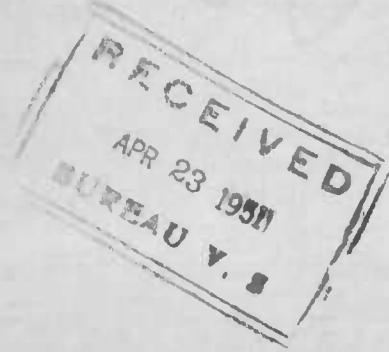
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)		(State)	
REG. 4-17-57		4-29-51		Congregational Cemetery		Wash. D.C.			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
4-17-57		J. H. Lamb, D.D.S.		W. W. Chapman, Jr.		1930 Chapin St. N.W. Wash. D.C.			



Reg. Dist. No. 223

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH. COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE		Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN		TOWN	
TOWNSHIP		8 mo		STREET		Takoma Park		Montgomery	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		ADDRESS		ADDRESS		(If rural, give location)		ADDRESS	
100 Belts Ave.		100 Belts Ave.		100 Belts Ave.		Takoma Park		Montgomery	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH		(Month)	(Day)	(Year)
William E. Chittenden					Feb	20	1951		
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday	
Male		White		Widowed		February 8, 1869		82	1. If under 1 year Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY			
Brewer		Brewing		Milford, Delaware		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
Ansor Chittenden		Emma Gray		No		Not available		Mrs. Louise C. Wallace, 5620 Colorado Ave. N.W.	
18. MEDICAL CERTIFICATION									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
<p>Immediate cause (a) Coronary occlusion</p> <p>Antecedent cause(s) (b) sudden death</p> <p>Diseases or conditions, if any, giving rise to the above cause (c) death</p> <p>920.1 94a</p>									
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?					
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?					
TIME (Month) (Day) (Year) (Hour) OF INJURY		m.							
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>									
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED			
Frank J. Brochart, M.D.				Gaithersburg, Md		4-20-51			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)		(State)	
Cremation		April 20, 1951		Cedar Hill Cemetery		Prince Co. Md.		Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
4-20-51		J. H. Hamm		Arthur Deters, 254 Carroll St. New York					



APR 23 1951

FEDERAL BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place) 18 days		2. USUAL RESIDENCE (HOME) OF DECEASED STATE WIS. CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS Milwaukee, 918 South 30th St.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hosp -					
3. NAME OF DECEASED (Type or Print) Martin		(First) (Middle) (Last) James Cody		4. DATE OF DEATH April 29 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH Oct. 6 1893	9. AGE last birthday 57 yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine		10b. KIND OF BUSINESS OR INDUSTRY Cutler-Hammer Co.		11. BIRTHPLACE (State or foreign country) Minnesota	
13. FATHER'S NAME Matthew Cody		14. MOTHER'S MASTEN NAME Rose P Nelson		12. CITIZEN OF WHAT COUNTRY U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 388-03-9662		17. INFORMANT AND ADDRESS Daughter June E O'Brien 1600 N. Kern Rd., Whiteman, Md.	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause 33 IX		(a) Cerebral Hemorrhage 8 days			
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause 83a		(b) Cerebral arteriosclerosis 10 yrs			
		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE None		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) OF INJURY	(Day) m.	(Year) 1951	(Hour) m.	INJURY OCCURRED While at Work	HOW DID INJURY OCCUR? At work
22. I hereby certify that I attended the deceased from 21 April, 1951, to 29 April, 1951, that I last saw the deceased alive on 28 April, 1951, and that death occurred at 11:30 a.m., from the causes and on the date stated above.					
SIGNATURE Merton L. White		(Degree or title) M.D.		ADDRESS 9715 Georgia Ave., Silver Spring, Md., 20991	
23. BURIAL, CREMATION REMOVAL (Specify) Trans. & Burial		DATE THEREOF May 3, 1951		NAME OF CEMETERY OR CREMATORIAL unknown	
LOCATION (City, town, or county) Milwaukee, Wisconsin		(State)			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE Frances P. L. P. Teller		24. FUNERAL DIRECTOR Warren D. Humphrey	
				ADDRESS 8434 Ga. Ave., Silver Spring, Maryland	

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MAY 1 1951  
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

3874

Reg. Dist. No. 214

The correct  
margin

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. It is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MONTGOMERY MARYLAND Cherry Chase 2 yrs 716 E. Leland St.		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE CITY TOWN STREET ADDRESS		MARYLAND Cherry Chase (If rural, give location) 716 E. Leland St.		
3. NAME OF DECEASED (Type or Print)		(First) Grace	(Middle) Gruelle	(Last) Cole	4. DATE OF DEATH	(Month) Apr	(Day) 25	(Year) 1951
5. SEX		6. COLOR OR RACE Female white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH 12-12-1874	9. AGE last birthday 76 yrs.	If under 1 year Months	If under 24 hrs Days	If under 1 min Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Bellevue govern't Clerk</i> <i>Banking office</i>		11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME <i>John M. Gruelle</i>		14. MOTHER'S MAIDEN NAME <i>Frances Julian</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT AND ADDRESS <i>Esther H. Cole</i>								
18. MEDICAL CERTIFICATION								
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								
Immediate cause <i>420.1</i>		(a) <i>Coronary occlusion</i>						
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause <i>97a</i> <i>stating the underlying cause last</i>		(b) <i></i>						
		(c) <i></i>						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?				
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .								
SIGNATURE <i>Frank J. Brochart M.D.</i>		(Degree or title) ADDRESS <i>Montgomery Md.</i>						
23. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>		DATE THEREOF <i>4-30-51</i>		NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>		LOCATION (City, town, or county) (State) <i>Prince George's Co. Md.</i>		
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <i>Frances Cole</i>		24. FUNERAL DIRECTOR <i>The 8th Avenue Wash. D.C.</i>		ADDRESS <i>390916</i>		

RECEIVED  
MAY 1 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3875

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY: <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE: <u>D. C.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR (give nearest town) TOWN: <u>Bethesda</u>		LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS: <u>Suburban Hospital</u> <u>8600 Old Georgetown Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Helen</u>		4. DATE OF DEATH 4 2 1951	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>Dec. 13 1876</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Andrew Hart L. Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Helen Mary Hoffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause

(a) Pneumonia, Lobar

4 days

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) Senility

20 yrs +

108

(c) Hypertensive Heart Disease

20 yrs +

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY						
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work	Not While At work	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/10, 1951, to 4/1, 1951, that I last saw the deceased  
alive on 3/1, 1951, and that death occurred at 5:10 A.M., from the causes and on the date stated above.  
SIGNATURE J. D. Hoffman M.D. ADDRESS 2741 34th St. N.W. April 2 1951 DATE SIGNED April 2 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/4/51</u>		NAME OF CEMETERY OR CREMATORIAL <u>The Rock Creek and</u>		LOCATION (City, town, or county) <u>Capitol Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>4-2-51</u>		REGISTRAR'S SIGNATURE <u>Helen K. Hoffman</u>		24. FUNERAL DIRECTOR <u>Joe F. B. Richardson</u>		ADDRESS <u>3034 M St. N.W.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

3876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>HYATTSSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HYATTSSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EDNA</u>		STREET ADDRESS <u>(If rural, give location)</u>	
3. NAME OF DECEASED (Type or Print) <u>EDNA</u>	(First) <u>EDNA</u>	(Middle) <u>M.</u>	(Last) <u>COOKMAN</u>
4. DATE OF DEATH <u>APRIL 20, 1957</u>	(Month)	(Day)	(Year)
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JUNE 1, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>EZEKIAL COOKMAN</u>	14. MOTHER'S MAIDEN NAME <u>FRANCES CRALLE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT AND ADDRESS <u>Mrs. L. E. McGILL - HYATTSSTOWN, MD.</u>	
18. MEDICAL CERTIFICATION			
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>Immediate cause (a) <u>Coronary Thrombosis</u>  <u>Arterio Sclerosis</u></p> <p>420.1 Antecedent cause(s) (b) <u>—</u>    Diseases or conditions, if any, giving rise to the above cause    stating the underlying cause last</p> <p>94a (c) <u>—</u></p>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 years</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) <u>INJURY</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>—</u>	(CITY OR TOWN) <u>—</u>
(CITY OR TOWN) <u>—</u>	(COUNTY) <u>—</u>	(STATE) <u>—</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec 10 1951 10:30 P.M.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>Dec 10, 1951</u> , to <u>Apr 16, 1951</u> , to <u>Apr 20, 1951</u> , that I last saw the deceased alive on <u>Apr 16, 1951</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Ernest P. Roop, M.D.</u> (Degree or title) <u>New Market</u> ADDRESS <u>—</u> DATE SIGNED <u>—</u> <u>Maryland</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 20, 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Congressional Cemetery</u>	LOCATION (City, town, or county) <u>Washington, D.C.</u>
DATE REC'D BY LOCAL REG. <u>April 21, 1951</u>	REGISTRAR'S SIGNATURE <u>Delta W. Burdette</u>	24. FUNERAL DIRECTOR <u>Janet Bryan, Inc., 312 Pa. Ave., N.E.</u>	ADDRESS <u>6333 VV</u>

RECEIVED

APR 25 1950

BUREAU V. S.

Item 18, 19a on:

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3878

FILE NO. G 152 MAY 15 1951

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>216 Highland Avenue</u>		STREET ADDRESS <u>216 Highland Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Ellen</u>	(First) <u>E.</u>	(Middle) <u>E.</u>	4. DATE OF DEATH <u>APR 21 1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 24, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>67</u>
13. FATHER'S NAME <u>Andrew Edward</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>William K. Craigie, Sr. - Husband</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Edward</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) <u>Cardio - respiratory failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u></p> <p>153 Antecedent cause(s) (b) <u>Carcinomatous c areas</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Primary site - carcinoma of the colon</u></p> <p>462 <u>cachexia</u> (5/15/51 akc)</p>			
<p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (d) <u>None</u></p>			
19a. DATE OF OPERATION <u>6 mos. prior to death</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of the colon resected</u>		
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m.	HOW DID INJURY OCCUR? Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Apr. 21, 1951</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:10 P.m.</u> , from the causes and on the date stated above. SIGNATURE <u>Stephen R. Jones, M.D.</u> ADDRESS <u>326 E. Montgo. Ave. Rockville Md.</u> DATE SIGNED <u>APR 21 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF <u>April 24, '51</u>	NAME OF CEMETERY OR CREMATORIAL <u>Rockville Union</u>	LOCATION (City, town, or county) <u>Rockville Maryland</u>
DATE REC'D BY LOCAL REG. <u>4-23-51</u>	REGISTRAR'S SIGNATURE <u>Helen S. Eckenfelder</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED

APR 24 1951

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

3879

1. PLACE OF DEATH COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u>		COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>31 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium Hospital</u>		STREET ADDRESS <u>213 Raymond St.</u>					
3. NAME OF DECEASED (Type or Print) <u>Grace</u>		(First) <u>Maude</u> (Middle) <u>Crandall</u> (Last)		4. DATE OF DEATH <u>4 26 1951</u>		(Month) (Day) (Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>12-29-79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Horticulture</u>		11. BIRTHPLACE (State or foreign country) <u>Jefferson, Wisconsin</u>		9. AGE last birthday <u>71</u> yrs.	
13. FATHER'S NAME <u>William Harrison Hake</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hake</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION							

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) Coronary Thrombosis with infarction

days

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) Hypertension Cardiosclerotic disease

years

Right pulmonary embolism

days

Left bronchopneumonia & cerebral embolism

days

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY		TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3-31, 1951, to 4-26, 1951, that I last saw the deceased  
alive on 4-26, 1951, and that death occurred at 8:59 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED 4-26-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4-30-51</u>	NAME OF CEMETERY OR CREMATORIAL <u>Arlington Catt. Barn</u>	LOCATION (City, town, or county) <u>Arlington, Va</u>	(State) <u>Va</u>
DATE REC'D BY LOCAL REG. <u>4-16 51</u>		REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>		24. FUNERAL DIRECTOR ADDRESS <u>Joseph Gulevich 1756 Pa. Ave N.W. Washington, D.C.</u>	

RECEIVED  
MAY 1 1951  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3880

## CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>District of Columbia</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Bethesda, Rural</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Washington</b>	
LENGTH OF STAY (in this place) <b>4 days</b>		STREET ADDRESS <b>4911 Arkansas Avenue, NW</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U. S. Naval Hospital</b>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>Eleanor</b>	(First)	(Middle) <b>Katherine</b>	(Last) <b>CRONAN</b>
4. DATE OF DEATH <b>April 2, 1951</b>	(Month)	(Day)	(Year)
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug 28, 1888</b>
9. AGE last birthday If under 1 year Months <b>62 yrs. 07 mos. 04</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>
13. FATHER'S NAME <b>Elmer E. STITZEL</b>	14. MOTHER'S MAIDEN NAME <b>Mary UNK</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. - - - - -	17. INFORMANT AND ADDRESS <b>Husband: Phillip G. CRONAN</b>	18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <b>420.0</b>	(a) <b>Hepatocirrhosis (cirrhosis)</b>	INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>93d</b>	(b) <b>Arteriosclerotic heart disease</b>	bility.	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN) <b>(CITY OR TOWN)</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Apr 2 1951 9:35 A.M.</b>		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? Not While <input type="checkbox"/>
22. I hereby certify that I attended the deceased from <b>Mar 29, 1951</b> , to <b>Apr 2, 1951</b> , that I last saw the deceased alive on <b>Apr 2, 1951</b> , and that death occurred at <b>9:35 A.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>E. M. SPAULDING</b>		(Degree or title) ADDRESS <b>U.S. NAVAL HOSPITAL</b>	
DATE SIGNED <b>April 2, 1951</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Apr 6, 1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
DATE RECD BY LOCAL <b>Apr 12, 1951</b>	REGISTRAR'S SIGNATURE <b>Edgar W. Spaulding</b>	24. FUNERAL DIRECTOR ADDRESS <b>Deal Funeral Home, 4812 Georgia Avenue, NW, Washington, D.C.</b>	



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ITEM 7:  
MARRIED.

letter from Capt. Gross, USN HOSP Bethesda, filmed 5-4-51 G132 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3881

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chevy Chase	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS 4716 Chevy Chase Blvd.	
3. NAME OF DECEASED (First) (Type or Print) John		(Middle) Hoff	
(Last) CROSS		4. DATE OF DEATH April 29, 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Apr 18, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not known		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John T. CROSS		14. MOTHER'S MAIDEN NAME Wife: Florence G. Cross	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Son: Howard CROSS		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 4150.0 (a) PYELONEPHRITIS, ACUTE (WITH UREMIA) 3 Days			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause 97 (b) HYPERTROPHY OF PROSTATE, BENIGN 15 yrs.			
stating the underlying cause last (c) ARTERIOSCLEROSIS, GENERALIZED (MARKED) 20 yrs.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. HERNIA, ING., INDIR., INCARCERATED (WITH PERITONITIS)			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Apr 16, 1951, to Apr 29, 1951, that I last saw the deceased alive on Apr 29, 1951, and that death occurred at 1:44 P.m., from the causes and on the date stated above. (Degree or title) ADDRESS DATE SIGNED J. S. HANTEN, CDR, MC, USN U.S. NAVAL HOSPITAL April 30, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 2, 1951	
DATE REC'D BY LOCAL REG. Apr 30, 1951		NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery	
REGISTRAR'S SIGNATURE Evel Whittington		LOCATION (City, town, or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR Donovan Funeral Home, 3818 Roland Avenue, Baltimore, Maryland		ADDRESS R7B	

REASON TO SUSPECT ANOTHER PERSON  
IN THIS CASE

REASON TO SUSPECT ANOTHER PERSON  
IN THIS CASE

RECEIVED  
MAY 2 1951

FBI  
BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3882

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH Montgomery County, Maryland		2. USUAL RESIDENCE (HOME) OF DECEASED Montgomery County, Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		LENGTH OF STAY (in this place) 10 days	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery General Hospital		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
3. NAME OF DECEASED (First) Eliza (Middle) Jane (Last) Crotts		4. DATE OF DEATH April 16, 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 18, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 80 yrs.
13. FATHER'S NAME Rose Crotts		11. BIRTHPLACE (State or foreign country) North Carolina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.			
17. INFORMANT AND ADDRESS Chester Crotts - Son - Deceased			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Chronic hypertension cardiovascular disease Antecedent cause(s) (b) Diabetes mellitus Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 61 (c)			
20 yrs 20+ yrs			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE R60X 61	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN) ADDRESS
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 3/28, 1951, to 4/16, 1951, that I last saw the deceased alive on 4/15, 1951, and that death occurred at 2:55 A.M., from the causes and on the date stated above.			
SIGNATURE A. D. Bonjard		(Degree or title) M.D.	ADDRESS Sandy Spring, Md. DATE SIGNED 4/16/51
23. BURIAL, CREMATION REMOVAL (Specify) Burial & Removal	DATE THEREOF 16 April 1951	NAME OF CEMETERY OR CREMATORIAL Mt. Tabor Cemetery	LOCATION (City, town, or county) Washington, D.C. (State)
DATE REC'D BY LOCAL REG. 4-16-51	REGISTRAR'S SIGNATURE Bertrude B. Fowler	24. FUNERAL DIRECTOR Walter E. Humphrey	ADDRESS Silverside Md.

RECEIVED

APR 18 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Olney LENGTH OF STAY (in this place) 3 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clarksburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mont. Co. Gen. Hospital		STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)	(First) Francis	(Middle) F.	(Last) Dahler		
4. DATE OF DEATH April 10	(Month)	(Day)	(Year) 1951		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 29-1887		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Foundry worker at Navy Yard	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Agusta Dahler	14. MOTHER'S MAIDEN NAME Amelia L. Gasch				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW #1	17. INFORMANT AND ADDRESS Mrs Mabel S. Dahler, Clarksburg, Md			
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
Immediate cause 723.0	(a) Bilateral bronchopneumonia		3 days		
Antecedent cause(s) 131a	(b) Chronic glomerulonephritis		2 years		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hypertrophic arthritis, generalized Silversis		5 years		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			10 years		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from June 15, 1947, to April 10, 1951, that I last saw the deceased alive on April 9, 1951, and that death occurred at 7:00 P.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED James D. Kerr M.D. 4/11/51					
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Apr. 13, 1951	NAME OF CEMETERY OR CREMATORIUM Bethesda	LOCATION (City, town, or county) (State) Browningsville, Md.		
DATE REC'D BY LOCAL REG. 4-12-51	REGISTRAR'S SIGNATURE Barbara B. Lawler	24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.	ADDRESS		

RECEIVED

APR 16 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3884

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

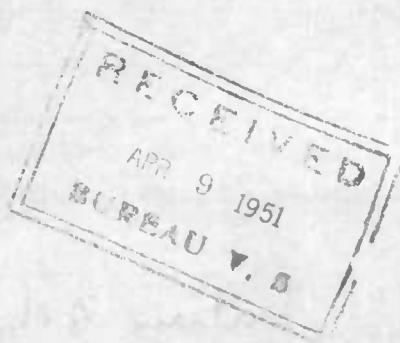
1. PLACE OF DEATH: COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Virginia</u> COUNTY <u>Alabama</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>6 mo</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u> <u>6700 Old Georgetown Rd.</u>		STREET ADDRESS <u>1744 Richmond Hwy</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>W</u>	(Last) <u>DAVIS</u>
4. DATE OF DEATH <u>Apr 4</u>	(Month) <u>Apr</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>mr</u>	8. DATE OF BIRTH <u>Sep 7 1884</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buitlong</u>	9. AGE last birthday If under 1 year Months <u>66</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
13. FATHER'S NAME <u>Charles Davis</u>	11. BIRTHPLACE (State or foreign country) <u>Trenton maine</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME <u>Celia Marshall</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
17. INFORMANT AND ADDRESS <u>Medical chart Royal 7 Patient</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Immediate cause <u>(a) Acute Congestive Heart Failure with edema</u>	
Antecedent cause(s) <u>540.0</u>		Diseases or conditions, if any, giving rise to the above cause <u>(b) 117a</u>	
Conditions contributing to the death but not related to the disease or condition causing death. <u>II. OTHER SIGNIFICANT CONDITIONS</u>		Causal factor <u>(c) Post-Operative Gastric Resection</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Causal factor <u>Bleeding Peptic Ulcer</u>	
19a. DATE OF OPERATION <u>Mar. 31, 1951</u>	19b. MAJOR FINDINGS OF OPERATION <u>Bleeding Peptic Ulcer</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	

20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>				
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>47</u> , to <u>Apr. 4</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Apr. 3</u> , 19 <u>51</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.		
SIGNATURE <u>Karl Dottbach MD</u>	ADDRESS <u>3130 Wisconsin Ave. NW</u>	DATE SIGNED <u>4/4/51</u>

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Apr. 6, 1951</u>	NAME OF CEMETERY OR CREMATORIAL CEREMONY <u>Cedar Hill</u>	LOCATION (City, town, or county) (State) <u>Suitland Md</u>
DATE REC'D BY LOCAL REG. <u>4-4-51</u>	REG. <u>4-4-51</u>	REGISTRAR'S SIGNATURE <u>Jeanne Fuerst</u>	FUNERAL DIRECTOR <u>Geo W. White Jr</u>
ADDRESS <u>2900 W St NW</u>		ADDRESS <u>2900 W St NW</u>	



Reg. Dist. No. 2, 8

## CERTIFICATE OF DEATH

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED  
APR 16 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3886

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda			LENGTH OF STAY (in this place)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase, Md.		
3. NAME OF DECEASED (First) BRENTIE (Type or Print)			4. DATE OF DEATH April 16 1951		
(Middle) R.			(Last) DELLINGER		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 17, 1878	9. AGE last birthday 72 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Va.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME O.G. Ridgeway			14. MOTHER'S MAIDEN NAME Sarah Brown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT AND ADDRESS Mrs. Emily D. Beall, 4532 Fairfield Dr. Bethesda, Md.		

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause

(a) Cerebral Hemorrhage,

3 days

442x Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause

(b) Cardio-vascular - renal disease

5 yrs.

46d

stating the underlying cause last

(c) Adeno-carcinoma of rectum

3 yrs

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

July 12, 1947 Adeno-carcinoma rectum

Yes  No 

21. ACCIDENT

(Specify)

PLACE (Home, farm, factory, street,  
of office bldg., etc.)

(CITY OR TOWN)

(COUNTY) (STATE)

SUICIDE

INJURY

HOMICIDE

INJURY

TIME (Montb) (Day) (Year) (Hour) INJURY OCCURRED  
OF While at Not While  
INJURY m. Work  At work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 13, 1951, to April 16, 1951, that I last saw the deceased

alive on April 16, 1951, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE Cousins

(Degree or title)

ADDRESS

DATE SIGNED  
4-16-5123. BURIAL, CREMATION  
REMOVAL (Specify)

## DATE THEREOF

REG.

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town, or county)

(State)

Apr. 18, 1951 Dellinger Cem.

Walterboro, S.C.

## DATE REC'D BY LOCAL

REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

REG.

REG.

Frances Potter

Cheng Chien David Wong - 5103 2nd

line 3rd

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3887

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY Arlington			
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR, give nearest town) TOWN Bethesda, Rural (in this place) 7 hours				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arlington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS 104 South Columbus Street (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) Jo	(Middle) Ann	(Last) DIXON	4. DATE OF DEATH April 27,	(Month) 1951	(Day) 1951
5. SEX Female		6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Feb 6, 1948	9. AGE last birthday 03 yrs.	If under 1 year Months 02	If under 24 hrs. Days 21 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Thomas D. DIXON				14. MOTHER'S MAIDEN NAME Josephine H. KAFEL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) NO				16. SOCIAL SECURITY NO. - - - - -			
17. INFORMANT AND ADDRESS Father: Thomas D. DIXON				18. MEDICAL CERTIFICATION Same as item # 2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) CARDIAC ARREST				INTERVAL BETWEEN ONSET AND DEATH None			
550.1 Antecedent cause(s) Diseases or conditions, if any, (b) APPENDICITIS, ACUTE WITH PERFORATION giving rise to the above cause stating the underlying cause last 121 AND PERITONITIS				48 hrs			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr 27, 1951, to Apr 27, 1951, that I last saw the deceased alive on Apr 27, 1951, and that death occurred at 4:55 P.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED							
H. S. ARNOLD, LT JG, MC, USN U.S. NAVAL HOSPITAL				April 27, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Apr 30, 1951		NAME OF CEMETERY OR CREMATORIAL Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REG. 27, 1951		REGISTRAR'S SIGNATURE Edd Whittington		24. FUNERAL DIRECTOR Fitzgerald Funeral Home, Arlington, Virginia		ADDRESS	

STATE OF MICHIGAN  
DEPARTMENT OF STATE  
CERTIFICATE OF DEATH

DETROIT  
MICHIGAN  
APR 2 1951  
BUREAU V. &

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3888

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		MARYLAND COUNTY MONT.	
CITY (If outside corporate limits, write RURAL and OR gloo nearest town) TOWN		Bethesda LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Chevy Chase (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Suburban Hosp		STREET ADDRESS		8211 Meadowbrook Dr.	
3. NAME OF DECEASED (Type or Print)		(First) MARY (Middle) K (Last) DOCKERY	4. DATE OF DEATH		APRIL 29	1951	
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year	If under 24 hrs.
Female		White	Widowed	Mar 25 1877	74	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Housewife		Housewife		Ireland		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
John McDowell		Ann Cox		Ellen Dockery		17. INFORMANT AND ADDRESS	
18. MEDICAL CERTIFICATION		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) Ac. ANTERIOR Myocardial Infarction GENERALIZED ARTERIOSCLEROSIS		Yes <input type="checkbox"/> No <input type="checkbox"/>		13 APR. 51.	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) ARTERIO-EMBOLISM BOTH FEMORALS AND BITURCATION OF AORTA.				27 APR. 51.	
93d		(c) CONGESTIVE HEART FAILURE				16 APR. 51	
21. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		22. DATE OF OPERATION		23. MAJOR FINDINGS OF OPERATION		24. ACCIDENT SUICIDE HOMICIDE	
None		None		None		None	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		(CITY OR TOWN)	
NOV 25 1951		m.		None		(COUNTY)	
(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		ADDRESS		(STATE)	
INJURY		INJURY		SILVER SPRING, MD.			
25. I hereby certify that I attended the deceased from 13 APR., 1951, to 29 APR., 1951, that I last saw the deceased alive on 28 APR., 1951, and that death occurred at 10:30 A.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED		ADDRESS		SILVER SPRING, MD.		DATE SIGNED	
26. BURIAL/CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State)	
april 24, 1951		St. John's Cemetery		New York, N.Y.			
DATE REC'D BY LOCAL REG. 4-29-51		REGISTRAR'S SIGNATURE Bessie M. Thompson		27. FUNERAL DIRECTOR		ADDRESS 4812 Rock Creek Rd. Washington, D.C.	

RECEIVED  
MAY 15 1961  
BUREAU W. S.

3889

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY <i>Montgomery</i>			MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>			COUNTY <i>Montgomery</i>					
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Takoma Park</i>			LENGTH OF STAY (In this place) <i>15 hrs.</i>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Silver Spring</i>			STREET ADDRESS <i>RFD #12</i>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>West. San. + Hosp.</i>														
3. NAME OF DECEASED (Type or Print) <i>Hezekiah</i>			(First) (Middle) (Last) <i>Hezekiah Dodson</i>			4. DATE OF DEATH <i>Apr. 2x 1951</i>			(Month) (Day) (Year)					
5. SEX <i>Male</i>			6. COLOR OR RACE <i>White</i>			7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>			8. DATE OF BIRTH <i>4-9-1883</i>			9. AGE last birthday If under 1 year Months Yrs. <i>68</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Street Car Motorman</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Street Car Motorman</i>			11. BIRTHPLACE (State or foreign country) <i>Ja.</i>			12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>					
13. FATHER'S NAME <i>John E. Dodson</i>						14. MOTHER'S MAIDEN NAME <i>Susan A. Bunker</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>83b</i>			16. SOCIAL SECURITY NO. <i>332-83-1234</i>			17. INFORMANT AND ADDRESS <i>Florrie J. Dodson</i>								

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

*332X* Immediate cause

(a) *Elevation of Basilar artery  
with softening of pons*

*15 hrs.*

*83b* Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No

21. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  PLACE (Home, farm, factory, street,  
CAUSE OF DEATH. OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED  
OF  
INJURY While at Not while  
m. work  at work  HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, DATE THEREOF, NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)  
REMOVAL (Specify) *Burial* *April 27, 1951* *Brownsville, Md.*

DATE REC'D BY LOCAL REG. 4-24-51 REGISTRAR'S SIGNATURE *J. Arthur Dodd* ADDRESS

24. FUNERAL DIRECTOR

*J. Arthur Daltres, 254 Carroll St NW  
661516 Washington 12, D.C.*

RECEIVED  
APR 27 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

3890

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY	
Montgomery		CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		Maryland	
TOWN Takoma Park		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN		OR	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Washington Sewell Hospital		Silver Spring Md.		TOWN	
Takoma Park		STREET		ADDRESS		If rural, give location	
				9719 Dilston Road			
3. NAME OF DECEASED (Type or Print)		(First) Unnamed		(Last) Dudley		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		5. DATE OF BIRTH	
Male		Wx.		4-17-37		9. AGE last birthday	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
11. FATHER'S NAME		Richard Wentworth Dudley		Takoma Park Maryland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME		17. INFORMANT AND ADDRESS	
				Hazel Marie Nelson		Hospital Records	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a)

Asphyxid.

1600

## Antecedent cause(s)

(b)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(c)

Respiratory Paralysis due to  
sub tentorial hemorrhage

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes

No

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
INJURY							
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work	Not While At work	HOW DID INJURY OCCUR?	
OF INJURY							

22. I hereby certify that I attended the deceased from 17 April, 1951, to 17 April, 1951, that I last saw the deceased

alive on 17 April, 1951, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Robert A. Bier, M.D. 8224-Georgia Ave., April 1951

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county)	
Cremation		4-19-51		Washington Sanitarium & Hosp.		Takoma Park, Md.	
DATE REC'D BY LOCAL REG.		REG. 4-19-51		REG. 4-19-51		ADDRESS	

written permission being given from both parents, B. J. Bier, M.D., Record Librarian  
2-04 17 32 2016



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Mont.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Bethesda</i> LENGTH OF STAY (in this place) TOWN <i>Bethesda</i> 6 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bethesda</i> STREET (If rural, give location) ADDRESS <i>8111 Custer Rd.</i>	
3. NAME OF DECEASED (Type or Print) <i>Ida Hair</i>		4. DATE OF DEATH <i>4 30 1951</i>	
5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Shawneetown Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin M. Hair</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Ridgway</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT AND ADDRESS <i>Mrs Catherine Head 5608 Edgewood Lane</i>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>15 hours.</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>Coronary thrombosis</i>		(a) <i>—</i> <i>15 days.</i>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>420.0</i> <i>93d</i>		(b) <i>Hypertension - arteriosclerotic heart disease</i> <i>With chronic glaucoma</i> <i>15 days.</i>	
		(c) <i>Central thrombosis with cerebral infarction</i> <i>9 months.</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>none</i>		19b. MAJOR FINDINGS OF OPERATION <i>—</i>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE <i>no</i> HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>—</i> (CITY OR TOWN) <i>—</i> (COUNTY) <i>—</i> (STATE) <i>—</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>—</i> <i>—</i> <i>—</i> <i>—</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR? <i>—</i>	
22. I hereby certify that I attended the deceased from <i>March 12, 1948</i> , to <i>April 30, 1951</i> , that I last saw the deceased alive on <i>April 30, 1951</i> , and that death occurred at <i>11:45 A.M.</i> , from the causes and on the date stated above. SIGNATURE <i>Bethman F. Schaefer, M.D.</i> (Degree or title) <i>—</i> ADDRESS <i>1801 X. St. N.W. Wash. D.C.</i> DATE SIGNED <i>4/30/51</i>			
23. BURIAL, CREMATION REMOVAL. (Specify) <i>Burial</i>		DATE THEREOF <i>5-3-51</i> NAME OF CEMETERY OR CREMATORIAL <i>Graceland Cem.</i> LOCATION (City, town, or county) <i>Chicago Illinois</i> (State) <i>—</i>	
DATE REC'D BY LOCAL REG. <i>4/30/51</i>		REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i> 24. FUNERAL DIRECTOR ADDRESS <i>The S.H. Hines Co. 1901-74 5th 52nd</i>	

RECEIVED

By <sup>2</sup> 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3892

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH. COUNTY MONTGOMERY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE MARYLAND	
CITY (If outside corporate limits, write RURAL and OR give nearest town) OLNEY TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROCKVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS THE MONTGOMERY COUNTY GENERAL HOSPITAL INC.		STREET ADDRESS R# 3 (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) BABY Kathleen	(Middle) GAIL	(Last) EDENS
4. SEX FEMALE	5. COLOR OR RACE WHITE	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	7. DATE OF BIRTH 3/28/51
8. AGE last birthday — yrs.	9. IF under 1 year Months 24	10. IF under 24 hrs. Days 3	11. If under 24 hrs. Hours 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH H. EDENS		14. MOTHER'S MAIDEN NAME OVIEDA MOORE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT AND ADDRESS Joseph H. Edens, Rockville, At. 3		18. MEDICAL CERTIFICATION Prematurity (32 weeks gestation) 24 days	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) —		Antecedent cause(s) (b) —	
776X Disease or conditions, if any, giving rise to the above cause 159 stating the underlying cause last (c) —		2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/28, 1951, to 4/21, 1951, that I last saw the deceased alive on 4/21, 1951, and that death occurred at 11 a.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED Sandy Spring, MD 4/21/51			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF April 28, 1951	
NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) Montgomery, MD		(State)	
DATE REC'D BY LOCAL REG. 4/23/51		REGISTRAR'S SIGNATURE Doris D. Bell	
24. FUNERAL DIRECTOR		ADDRESS Pete Barber, Rockville	

VS. A15  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Tick correct age.

MARGIN RESERVED FOR BINDING

is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 25 1951  
BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3893

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Virginia</b> COUNTY <b>Accomack</b>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Bethesda, Rural</b> LENGTH OF STAY <i>in this place</i> <b>1 day</b>			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Oak Hall</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U. S. Naval Hospital</b>			STREET ADDRESS <b>none</b>		
3. NAME OF DECEASED (First) <b>Cloyd</b> (Middle) <b>Gene</b> (Last) <b>EICHELBERGER</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 15, 1951</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Apr. 13, 1951</b>	9. AGE last birthday 00 yrs. 00 months 00 days 00 hours 00 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Wilmer G. EICHELBERGER</b>		14. MOTHER'S MAIDEN NAME <b>Marion SHAFFER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. - - - - -	17. INFORMANT AND ADDRESS <b>Father: Wilmer G. EICHELBERGER</b>		
18. MEDICAL CERTIFICATION <b>Same as item # 2</b>					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
754.4 Immediate cause (a) <b>Congenital Heart Disease</b>					
157e Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)		(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Apr. 14, 1951</b> , to <b>Apr. 15, 1951</b> , that I last saw the deceased alive on <b>Apr. 15, 1951</b> , and that death occurred at <b>7:28 A.m.</b> , from the causes and on the date stated above. SIGNATURE <i>L. W. Sederstrom</i> (Degree or title) <b>ADDRESS</b> DATE SIGNED <b>1951</b>					
23. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>		DATE THEREOF <b>Apr 15, 1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>Everett Cemetery</b>	LOCATION (City, town, or county) <b>Everett, Penn.</b>	(State)
DATE REC'D BY LOCAL <b>Apr 15, 1951</b>		REGISTRAR'S SIGNATURE <i>Ever Whittington</i>	24. FUNERAL DIRECTOR ADDRESS <b>R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.</b>		

RECEIVED  
APR 17 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

M  
The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (Home) OF DECEASED: STATE	
Montgomery MARYLAND		Md. Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town TOWN	
Tahoma Park.		Tahoma Park.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
20 Montgomery Ave		20 New Montgomery	
3. NAME OF DECEASED (Type or Print)	(First) May	(Middle) Ellen	(Last) Eshelman
4. DATE OF DEATH	(Month) April	(Day) 4	(Year) 1957
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Married	Mar 23 1877
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
74	Housewife	Conn.	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Henry McFadden	Mary Ann Sanders		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	
Yes	-	Edgar Eshelman	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) Cerebral Hemorrhage  
Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last  
(b) Ben Arturoclous 1 Day pulmonary  
(c) 18 days

## 83a 331X 83a 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day) m.	(Year) m.	INJURY OCCURRED While at Work	Not While At work	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/16/1936, to 4/4/1951, that I last saw the deceased alive on 4/3/1951, and that death occurred at 6 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
Burial	April 6, 1951	Arlington Hall Cemetery	Arlington, Va
DATE REC'D BY LOCAL REG.	REGISTRATION SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-4-51	J. Helton Dodd	J. Helton Dodd	254 Carroll St. Tahoma Park 22714

REVIEWED  
1951

1951

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3895

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Montgomery CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWNS		Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWNS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place)	
Washington San-Hosp		14 days	
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)	
Orlo Henry Frost			
4. SEX	5. COLOR OR RACE	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	7. DATE OF BIRTH
Male	Caucasian	MARRIED	11-30-1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday	
Court reporter		65 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Binghampton N.Y.	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles A. Frost		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT AND ADDRESS			
Hospital records			
18. MEDICAL CERTIFICATION			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) *Bladder, also of Jugular & Esophagus* 3/20/57

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last(b) *Arthritis of Liver*

(c)

*Causes Upper Resp. Infection (Virus)* 3/18/51

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
5810		7/2/49		Causes Upper Resp. Infection (Virus)		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
1246							
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
				INJURY			
TIME (Month) (Day) (Year)		(Hour)		INJURY OCCURRED While at Work		HOW DID INJURY OCCUR? Not While At work	
OF INJURY		m.					

22. I hereby certify that I attended the deceased from 12/1/50, 1950 to 4/16/51, 1951, that I last saw the deceased alive on 4/16/51, 1951, and that death occurred at 12:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED 4/7/51

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)	
Burial		4-10-51		St. Lincoln Cem.		Mt. George C. Md.	
DATE REC'D BY LOCAL REG.		REG. 4-7-51		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
				John D. Frank Joy		Washington D.C. 250 1/36	

RECEIVED  
APR 12 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

389b

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY		Montgomery Maryland			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Wheaton		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Wheaton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		1811 Arcola Ave.		STREET ADDRESS		1811 Arcola Avenue.			
3. NAME OF DECEASED (Type or Print)		(First) Maria	(Middle)	(Last) Fry	4. DATE OF DEATH	(Month) April	(Day) 24	(Year) 19 51	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE last birthday	
Female		White		MARRIED		11-5-92		58	If under 1 year Months. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Homemaker		Own Home		Germany		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
William Lott		Susanna S. Lott		(Yes, no, or unknown) (If year, give war or dates of service)		none		Silver Spring, Md.	
no		Mr. Wilfred C. Fry, 1811 Arcola Ave.							

18. MEDICAL CERTIFICATION										
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										
Immediate cause		(a)		Generalized Abdominal Carcinomatosis						INTERVAL BETWEEN ONSET AND DEATH
175X Antecedent cause(s)		(b)		Carcinoma Both Ovaries						1 year
17a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)		Cachexia, Ascites						1 year.
										3 months

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?					
17a		4-24-50		Carcinoma Both Ovaries		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg. etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
none				INJURY							
TIME (Month) OF INJURY		(Day)		(Year)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
none		m.		White		Not White					
				Work		At work					

22. I hereby certify that I attended the deceased from 1-26, 1951, to 4-24-1951, that I last saw the deceased alive on 4-24, 1951, and that death occurred at 5:00 p.m., from the causes and on the date stated above.									
SIGNATURE (Degree or title) ADDRESS DATE SIGNED									
McShaeuher M.D. 8005 Woodbury Dr. Silver Spring, Md. 4/24/51									

23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORIAL Warner E. Pumphrey Funeral		LOCATION (City, town, or county) Silver Spring, Montgomery Co.		(State)	
Temp. Entombment		4/28/51		Home					
DATE REC'D BY LOCAL REG.		REG.		REG.		24. FUNERAL DIRECTOR		ADDRESS	
Apr 27/51		Frances P. Lott		Warner E. Pumphrey		8434 Ga. Ave., Silver Spring		Maryland	

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U. S. DEPARTMENT OF JUSTICE

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

3897

1. PLACE OF DEATH COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>				
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Rockville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rockville</i>				
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <i>311 W. Mont Ave,</i>				
3. NAME OF DECEASED (Type or Print)	(First) <i>Buell</i>	(Middle) <i>Maryliss</i>	(Last) <i>Gardner</i>			
4. DATE OF DEATH	(Month) <i>April</i>	(Day) <i>13</i>	(Year) <i>1951</i>			
5. SEX	6. COLOR OR RACE <i>Male</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 13, 1898</i>			
9. AGE last birthday yrs.	10. KIND OF BUSINESS OR INDUSTRY <i>Painter - self employed</i>	11. BIRTHPLACE (State or foreign country) <i>New York</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>John Gardner</i>	14. MOTHER'S MAIDEN NAME <i>Gardner</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Yes</i>				
16. SOCIAL SECURITY NO. <i>W 0 1 0 0 1</i>		17. INFORMANT AND ADDRESS <i>Margaret Gardner, wife, Rockville</i>				
18. MEDICAL CERTIFICATION						
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
Immediate cause <i>Congestive Heart Failure -</i>						
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Rheumatic Heart Disease -</i>						
(a) <i>916X</i>						
(b) <i>958</i>						
(c) <i>Myocardial Infarction</i>						
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) <i>(CITY OR TOWN)</i>	(COUNTY) <i>(COUNTY)</i>	(STATE) <i>(STATE)</i>	
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work m.	Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <input type="checkbox"/>
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.						
SIGNATURE <i>Walker Welsh, M.D.</i>		(Degree or title) <i>(Degree or title)</i>		ADDRESS <i>Rockville, Maryland 41150</i>	DATE SIGNED <i>4/13/51</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>14 Apr. 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Parkwood Cemetery</i>	LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>(State)</i>	
DATE REC'D BY LOCAL REG. 4-16-51		REGISTRAR'S SIGNATURE <i>Helen S. Elsfield</i>	24. FUNERAL DIRECTOR ADDRESS <i>Bob V. J. Murphy, Bellona, Md.</i>			
470736						

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3898

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY	
Montgomery		Length of Stay (in this place)		Maryland		Montgomery	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		TOWN		CITY (If outside corporate limits, write RURAL, and give nearest town)		TOWN	
Bethesda		Bethesda		Bethesda		Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		5420 Glenwood Ave.		STREET ADDRESS		(If rural, give location)	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
Male		White		Married		9. AGE last birthday	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
Dept. of Defense		U.S. Gov.		Chicago, Ill.			
13. FATHER'S NAME		Robert N. Gilmore		14. MOTHER'S MAIDEN NAME		Not known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
Yes		W. W. I 220-26-2567		Mrs. Wm. ED Gilmore - Same		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 Immediate cause		(a) Coronary occlusion				sudden death.	
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		(b)					
		(c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State)	
Burial		13 Apr 1951		Arlington National		Arlington, Va.	
DATE REC'D BY LOCAL REG.		REG. 4-16-51		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
				Helen S. Eskenfelder		Robert A. Timphus, Bethesda, Md.	

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## MARYLAND STATE DEPARTMENT OF HEALTH

3899

Evidence for addition  
in 21 shown on:

H.M. No. G 122 APR 18 1951 FOR MEDICAL EXAMINERS

Reg. Dist. No. 223

1. PLACE OF DEATH CITY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED CITY		COUNTY	
Montgomery		MONTGOMERY		Maryland		P. G.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		STREET ADDRESS	
Takoma Park		1 hr.		Takoma Park		707 Fernside Rd.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Ward. Sanitarium & Hosp.		(If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(Middle)		4. DATE OF DEATH		(Month) (Day) (Year)	
Jeffrey		(Last)		Gladd		Apr 5 1951	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		9. AGE last birthday	
Male		White		Single		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
-		-		Ward DC		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.	
Clayton N. Gladd		Ingram, Beverly		(Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS	
170c		Mother					

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

812.5	Immediate cause	(a) Shock due to Concussion and	1 hr.
170c	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hemorrhage Separation of art. parietal and frontal suture (accidental)	
	(c)		

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

20. AUTOPSY?

Yes  No 

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, of office bldg. etc.) INJURY Street	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY Apr 5 1951 10:45 m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>	Takoma Park P. G. MD
		HOW DID INJURY OCCUR? struck by auto (4/17/51 a/c)

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF 4-7-51	NAME OF CEMETERY OR CREMATORIAL Kedar Hill	LOCATION (City, town, or county) St. George L. Mod.	(State)
DATE REC'D BY LOCAL REG.	REG. 4-5-51	REGISTRAR'S SIGNATURE J. Gladd	24. FUNERAL DIRECTOR J. W. Lee Son's Co.	ADDRESS 300 4th St. N.E. Washington 2, D.C.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3900

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

The correct age  
is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Silver Spring			TOWN Silver Spring		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 807 Islington St.			STREET ADDRESS (If rural, give location) 807 Islington Street		
3. NAME OF DECEASED (Type or Print)	(First) Harry	(Middle) P.	(Last) Godwin	4. DATE OF DEATH April 15	(Month) (Day) (Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH June 8, 1902	9. AGE last birthday 48	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber - worked for:			10b. KIND OF BUSINESS OR INDUSTRY Morris J. Colbert Co.		
13. FATHER'S NAME George W. Godwin			11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			12. CITIZEN OF WHAT COUNTRY USA		
16. SOCIAL SECURITY NO. 578-03-6043			17. INFORMANT AND ADDRESS Silver Spring, Md. Mrs. Anna Maria Godwin, 801 Islington St.		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p>151x Immediate cause (a) <i>Carcinoma of the bladder. about 1 yr.</i></p> <p>52b Antecedent cause(s) (b) <i>with spread of Ca throughout the abdomen</i></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>					
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION 3/21/51	19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of bladder &amp; intestines.</i>			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m.	Not While At work	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 3/4/51, to 4/15/51, that I last saw the deceased alive on 4/13/51, and that death occurred at 9:35 P.m., from the causes and on the date stated above.					
SIGNATURE <i>Angeline</i> (Degree or title)			ADDRESS		
DATE SIGNED 4/15/51					
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4/19/51	NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery	LOCATION (City, town, or county) Prince Geo. County	(State) Md.	
DATE REC'D BY LOCAL REG. <i>April 18/51</i>	REGISTRAR'S SIGNATURE <i>Frances Deller</i>	24. FUNERAL DIRECTOR			
		ADDRESS <i>Warren L. Murphy 8434 Ge. Ave., Silver Spring Maryland</i>			

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

3901

1. PLACE OF DEATH COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS <u>310 Essex St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>Griffith</u>	4. DATE OF DEATH <u>April 12</u>
5. SEX <u>Male</u>	COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	5. DATE OF BIRTH <u>Dec. 9, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Garage owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Garage</u>	9. AGE last birthday If under 1 year Months <u>82</u> yrs.
13. FATHER'S NAME <u>Samuel Griffith</u>		11. BIRTHPLACE (State or foreign country) <u>Kingsway, Canada</u>	12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT AND ADDRESS <u>Mrs. Harold F. Tanke</u>
18. MEDICAL CERTIFICATION			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

331X

Immediate cause

(a)

Respiratory Failure

1 hour

83a

Antecedent cause(s)

(b)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

Cerebral Hemorrhage

8 days

(c)

Hypertension, Advanced Arteriosclerosis

apply

10 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OCCURRED While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR? Not While At work <input type="checkbox"/>	
m.					

22. I hereby certify that I attended the deceased from November, 1950, to April 12, 1951, that I last saw the deceasedalive on April 12, 1951, and that death occurred at 10:40 A.M. from the causes and on the date stated above.  
SIGNATURE (Degree or title) Frank G. Jagger, Jr. M.D. ADDRESS 5707 Wisconsin Ave., Chevy Chase, Md. DATE SIGNED 4/12/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-13-51</u>	NAME OF CEMETERY OR CREMATORIAL <u>Crossview - Michigan</u>	LOCATION (City, town, or county) <u>Sanilac County, Michigan</u>	(State) <u>Michigan</u>
DATE REC'D BY LOCAL REG. <u>April 13, 1951</u>	REG. <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Frank Jagger, Bethesda, Md.</u>	ADDRESS <u>290816</u>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3902

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>	
LENGTH OF STAY (in this place) <u>9 days</u>		STREET ADDRESS <u>901 Flower Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium Hospital</u>		(If rural, give location)	
3. NAME OF DECEASED (First) (Type or Print) <u>Joseph</u>	(Middle) <u>Franklin</u>	(Last) <u>Haigh</u>	4. DATE OF DEATH <u>4 26 1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>8-23-94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk, Vets Ad.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	9. AGE last birthday <u>56</u> If under 1 year Months <u>yr.</u>
13. FATHER'S NAME <u>John F. Haigh</u>		11. BIRTHPLACE (State or foreign country) <u>Le Royville Pa.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War II</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT AND ADDRESS <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>(a) Cerebral hemorrhage, rt. temporal, parietal lobe</u> <span style="float: right;">8 days</span>			
Antecedent cause(s) <u>443X</u> <u>93d</u> <u>(b) Myocardial hypertrophy with arrhythmia</u> <span style="float: right;">Years</span>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last <u>(c) Hypertension arterio sclerotic bilateral</u> <span style="float: right;">11 1/2 yrs.</span>			
II. OTHER SIGNIFICANT CONDITIONS <u>1. Hypertrophy of adrenals, bilateral</u> <span style="float: right;">Unknown</span>			
Conditions contributing to the death but not related to the disease or condition causing death <u>2. Diverticulitis lower sigmoid</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Nov. 13, 1939</u> , to <u>Apr. 26, 1951</u> , that I last saw the deceased alive on <u>Apr. 25, 1951</u> , and that death occurred at <u>1 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Wallace N. Monk M.D.</u>		(Degree or title) <u>—</u>	ADDRESS <u>Takoma Park, Md.</u>
DATE SIGNED <u>4-26-51</u>			
23. BURIAL, CREMATION BURIAL <input checked="" type="checkbox"/> Cremation <input type="checkbox"/>		DATE THEREOF <u>5/1/51</u>	NAME OF CEMETERY OR CREMATORIAL <u>Tioga Point Cemetery</u>
			LOCATION (City, town, or county) <u>Athens, Bradford Co.</u> (State) <u>Pa.</u>
DATE REC'D BY LOCAL REG. <u>4-28-51</u>		REGISTRAR'S SIGNATURE <u>J. William Dodd</u>	24. FUNERAL DIRECTOR <u>Warren G. Bumprey</u>
			ADDRESS <u>8434 Ga. Ave., Silver Spring</u>
			MARYLAND <u>10916</u>



## MARYLAND STATE DEPARTMENT OF HEALTH

3903

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY	
Montgomery		CITY (If outside corporate limits, write RURAL and OR TOWN Rural Gaithersburg		LENGTH OF STAY (in this place)		Maryland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		24 W. 1st Montgomery Co. Capital Shopping		24 hrs.		Montgomery	
3. NAME OF DECEASED (Type or Print)		(First) JOHNIE	(Middle) W	(Last) HALL	4. DATE OF DEATH		(Month) (Day) (Year)
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday		If under 1 year Months Days Hours Min.
MALE		Coh	Single	June 17-1868	82 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
dy labor		On Farm		Maryland		USA	
13. FATHER'S NAME		William Hall		14. MOTHER'S MAIDEN NAME		Susan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
No		no		I am Doctor Gaithersburg		Immediate cause  a) Degenerative Heart Disease Not Antecedent cause(s) Diseases or conditions, if any, (b) manifested by congestive heart giving rise to the above cause stating the underlying cause last 93d (c)	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 4/22/51 Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last 93d (c)		Degenerative Heart Disease Not manifested by congestive heart failure, 92 w/ heart block.	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
						Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
INJURY		TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 3, 1951, to April 10, 1951, that I last saw the deceased alive on April 10, 1951, and that death occurred at 11:45 a.m., from the causes and on the date stated above.		ADDRESS		DATE SIGNED	
SIGNATURE: Jack Schinnerer M. D.		ADDRESS: Gaithersburg, Md. Apr. 10, 1951			

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)	
Burial		April 13, 1951		Brookside		Montgomery Co. Md. (State)	
DATE REC'D BY LOCAL REG. 4-13-51		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
		Burke B. Lawler		Roy W. Barber		Glenview, Ill.	

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APR 17 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3904

## CERTIFICATE OF DEATH

Reg. Dist. No... 212

1. PLACE OF DEATH COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Bellman, md</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Bellman, md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED (Type or Print)	(First) <i>Alfred</i>	(Middle) <i></i>	(Last) <i>Harper</i>	4. DATE OF DEATH <i>April 25</i>	(Month) <i>April</i>	(Day) <i>25</i>	(Year) <i>1957</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Dec. 22, 1879</i>	9. AGE last birthday <i>71 yrs</i>	If under 1 year Months	If under 24 hrs. Days	Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saxophone</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
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13. FATHER'S NAME <i>George C. Harper</i>	14. MOTHER'S MAIDEN NAME <i>Rose Lee</i>
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15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Joseph Harper</i>
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18. MEDICAL CERTIFICATION		
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I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
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Immediate cause <i>442X</i>	(a) <i>Uremia</i>	INTERVAL BETWEEN ONSET AND DEATH <i>30 hours</i>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>131a</i>	(b) <i>Hypertensive Cardiovascular Renal Disease.</i>	5 years.
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
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21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
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TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from <i>20 Apr., 1957</i> , to <i>25 Apr., 1957</i> , that I last saw the deceased alive on <i>25 Apr., 1957</i> , and that death occurred at <i>4:55 P.M.</i> , from the causes and on the date stated above.					
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SIGNATURE <i>Norman M. Smith</i>	(Degree or title) <i>M.D.</i>	ADDRESS <i>Barnesville, Md</i>	DATE SIGNED <i>25 Apr 57</i>
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23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>4/29/57</i>	NAME OF CEMETERY OR CREMATORIAL <i>Parolesville</i>	LOCATION (City, town, or county) <i>Parolesville, Md</i>
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DATE REC'D BY LOCAL REG.	REG. NO. <i>4/28/1957</i>	REG. NO. <i>820105</i>	REG. NO. <i>Robert L. Surden, Rockville, Md</i>
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RECEIVED

MAY 2 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3905

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>District of Columbia</b> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Bethesda, Rural</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Washington</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U. S. Naval Hospital</b>		STREET ADDRESS <b>4200 38th Street, N.W.</b>	
3. NAME OF DECEASED (Type or Print) <b>Helen</b>	(First) <b>Helen</b>	(Middle) <b>Baxter</b>	(Last) <b>HARPER</b>
4. DATE OF DEATH <b>April 4,</b>	(Month) <b>April</b>	(Day) <b>19</b>	(Year) <b>51</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 29, 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	9. AGE last birthday 49 yrs.	If under 1 year Months <b>10</b> Days <b>06</b> Hours <b>00</b> Min. <b>00</b>
13. FATHER'S NAME <b>William BAXTER</b>	14. MOTHER'S MAIDEN NAME <b>Kate MAC GILL</b>	11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>-----</b>	17. INFORMANT AND ADDRESS <b>Husband: John HARPER</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>
18. MEDICAL CERTIFICATION Same as item # 2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <b>157X</b>	(a) <b>CARCINOMA, PANCREAS</b>	INTERVAL BETWEEN ONSET AND DEATH <b>Indef.</b>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>46g</b>	(b) <b>-----</b>		
(c) <b>-----</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) <b>PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY</b>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? Not While	
22. I hereby certify that I attended the deceased from <b>Mar 13, 1951</b> , to <b>Apr 4, 1951</b> , that I last saw the deceased alive on <b>Apr 4, 1951</b> and that death occurred at <b>5:15 P.m.</b> , from the causes and on the date stated above. SIGNATURE <b>S. R. Mills</b> (Degree or title) <b>ADDRESS</b> DATE SIGNED <b>April 5, 1951</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Apr 6, 1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
DATE REC'D BY LOCAL REG. <b>Apr. 5, 1951</b>	REGISTRAR'S SIGNATURE <b>Ed Whittington</b>	24. FUNERAL DIRECTOR ADDRESS <b>R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland</b>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3906

## CERTIFICATE OF DEATH

Reg. Dist. No. 2231

1. PLACE OF DEATH. COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
Montgomery MARYLAND		District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Takoma Park LENGTH OF STAY (in this place)		TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium + Hospital		STREET ADDRESS 1500 Decatur St. N.W. ✓ (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Lena	(Middle) Elizabeth	(Last) Harris
4. DATE OF DEATH	4	(Month) 27	(Day) (Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH
Female Caucasian		Widowed	10-31-72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Louis F. Wolfe	Fannie E. Mac Lea		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	
None		Hospital Records.	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

181X

Immediate cause

(a) *Hemorrhage - Sec. Anemia*

10 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last(b) *Carcinoma Bladder -*

3 months +

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY		TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
		m.			

22. I hereby certify that I attended the deceased from *April 1st*, 1951, to *April 27, 1951*, that I last saw the deceased alive on *April 26, 1951*, and that death occurred at *4:20 A.M.*, from the causes and on the date stated above.  
SIGNATURE: *John F. Broenberger M.D.* ADDRESS: *Takoma Park - Maryland* DATE SIGNED: *APR 27 1951*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
	4-30-51	Rock Creek	Takoma Park	D.C.
DATE REC'D BY LOCAL REG.	REGISTRATION'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
4-22-51	<i>John Broenberger</i>	<i>Theodore H. Hines Co.</i>	2901 14th Street N.W. Washington, D.C.	

RECEIVED  
MAY 1 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3907

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Ohio</b> CITY <b>Youngstown</b> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Bethesda</b>		LENGTH OF STAY (in this place) <b>2 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Youngstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Alta Vista Rest Home</b>		STREET ADDRESS <b>224 W. Dennis St.</b>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>Francis E. Hearn</b>		(Last) <b>Hearn</b>		4. DATE OF DEATH <b>April 14</b>	(Month) <b>April</b> (Day) <b>14</b> (Year) <b>1951</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5 Sept. 1871</b>	9. AGE last birthday 99 yrs.	If under Months. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President of Hearn Paper Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>	
13. FATHER'S NAME <b>Thomas Hearn</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <b>6920 A Fairfax Rd Mrs Ralph L. Ingram Bethesda, Md.</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause **443X**(a) *Cardiac decompensation -*INTERVAL BETWEEN  
ONSET AND DEATH  
**48 hr.**Antecedent cause(s) **93d**Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last(b) *Infarct Block of Right lung from Embolism.***5 days.**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

(c) *Hypertension, Cardio Vascular disease severe -  
Generalized arteriosclerosis -  
Epileptic from convulsions from arteriosclerosis.***10 yrs.?****20 yrs.?****37 yrs.**

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? **Yes**  **No** 21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURYINJURY OCCURRED  
While at  
m. Work  At work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept. 1947**, to **14 April 1951**, that I last saw the deceasedalive on **13 April 1951**, and that death occurred at **2:30 A.m.**, from the causes and on the date stated above.  
(Degree or title) **John D. Ball** ADDRESS **7936 Lexington Rd. Bethesda Md. 195157.** DATE SIGNED23. BURIAL, CREMATION  
REMOVAL (Specify)  
**Burial-Transit**

DATE

**4/14/51**

NAME OF CEMETERY OR CREMATORIAL

**Tod Memorial**

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**4-16-51****Helen L. Eichenfeld Robert J. Humphrey****290456**

RECEIVED  
APR 17 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3908

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH. COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
Montgomery		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Takoma Park		TOWN Takoma Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San. + Hospital		STREET ADDRESS 911 Davis Ave.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH April 29 1951	
(First) Onie		(Last) Henderson	
(Middle)		(Month)	
5. SEX Female		6. COLOR OR RACE white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH 1-19-68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE last birthday 83 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME James W Howard		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Mrs. E. Babcock, 425 Whitter St. S.W. DC		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 442X		(a) Coronary Thrombosis	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Arteriosclerotic Cardiovascular Disease	
61		(c) Terminal Urinary & Endocrinopathy Diabetes Mellitus	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
INJURY		(CITY OR TOWN)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 10, 1951, to April 29, 1951, that I last saw the deceased alive on April 29, 1951, and that death occurred at 4:20 P.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 1, 1951	
		NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	
		LOCATION (City, town, or county) Prince George's County, Maryland	
VS. A15		(State)	
DATE REC'D BY LOCAL REG. 4-29-51		REGISTRAR'S SIGNATURE J. Marion Dodd	
		24. FUNERAL DIRECTOR	
		ADDRESS J. Arthur Deller 254 Carroll St. NW	
		Takoma Park, DC.	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3909

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH: COUNTY <u>MONTGOMERY</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u>		COUNTY <u>MONTGOMERY</u>					
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u>		(If rural, give location) STREET ADDRESS <u>908 Viers Mill Rd.</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS											
3. NAME OF DECEASED (Type or Print) <u>William H. Witheram</u>		(First) <u></u>	(Middle) <u></u>	(Last) <u>Higgins</u>	4. DATE OF DEATH <u>4-17</u>	(Month) <u>1951</u>	(Day) <u></u>	(Year) <u></u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE <u></u>	MARRIED <u></u>	WIDOWED <u></u>	DIVORCED <u></u>	8. DATE OF BIRTH <u>3-11-1857</u>	9. AGE last birthday <u>94</u>	If under 1 year Months <u>0</u>	If under 24 hrs. Days <u>0</u>	If under 24 hrs. Hours <u>0</u>	Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13. FATHER'S NAME <u>William H. Witheram</u>				14. MOTHER'S MAIDEN NAME <u>Jane Higgins</u>		17. INFORMANT AND ADDRESS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u></u>									

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Arteriosclerosis, my cardiac failure Bleeding

## Antecedent cause(s)

(b) Religious catarracts, with blindness 10 years

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last

(c) Senility —

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None19b. MAJOR FINDINGS OF OPERATION —

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1940, 19....., to April 17, 1951, that I last saw the deceased alive on April 15, 1951, and that death occurred at 355A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED 4/17/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Apr. 19, 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Cedar Hill Cem.</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>	(State) <u></u>
DATE REC'D BY LOCAL REG. <u>4/19/51</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Eckenfelder</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>	ADDRESS <u>1400 Columbia St</u>	<u>Wash. D.C.</u>
Per. C.L. 777 see				

RECEIVED  
APR 20 1951  
BUREAU V. S.

3910

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 247-1

1. PLACE OF DEATH. COUNTY				2. USUAL RESIDENCE (HOME) OF DECEASED. STATE										
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN										
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS										
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH		(Month)	(Day)	(Year)					
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH		9. AGE last birthday		If under 1 year yrs.	If under 24 hrs Months	If under 24 hrs Days	If under 24 hrs Hours	Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY						
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS				
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH										
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH														
420.1 Immediate cause				(a) <i>Coronary atherosclerosis</i>										
Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last				(b) <i>dead in bed.</i>										
94a				(c)										
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.														
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION												
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY				(CITY OR TOWN)				(COUNTY)		(STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?										
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .														
SIGNATURE <span style="float: right;">DATE SIGNED</span> <i>Frank J. Broschart M.D. 4-1-51</i>														
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county)		(State)						
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS								
4-1-51		Bertie M. Lewis		Robert A. Humphrey - Bethesda		Md. 100-105								

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

3911

Reg. Dist. No. 215

1. PLACE OF DEATH. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE		District of Columbia	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Bethesda, Rural		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		U. S. Naval Hospital		1 mo 25 da		Washington	
3. NAME OF DECEASED (Type or Print)		(First) Garland	(Middle) Herbert	(Last) HUDSON	4. DATE OF DEATH		(Month) April 7, 1951
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday		(Year)
Male		Negro	Married	7-12-87	63	If under 1 year Months 8	If under 24 hrs Days 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Book Binder		Govt P.O.		Tennessee		US	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. INFORMANT AND ADDRESS		Wash., D.C.	
Frank HUDSON		Betty GARLAND		Wife: Ora HUDSON 1916 W. Va. Ave NE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
YES 1918-19							

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *pulmonary embolism (massive)*  
(b) *bilateral*  
(c)

*4/15 X* Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

*Old unhealed fracture of left tibia*

*2 yrs.*

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
--	--	---	--	----------------	----------	---------

TIME (Month) (Day) (Year)	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?				
OF INJURY	m. <input type="checkbox"/> at work <input type="checkbox"/>					

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

*Frank J. Broschart*

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
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Burial	Apr. 12, 1951	Arlington National	Arlington, Virginia	ADDRESS
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DATE REC'D BY LOCAL REG. APR 8, 1951 REGISTRAR'S SIGNATURE *Evel Whittington* 24. FUNERAL DIRECTOR W.E. JARVIS 1432 U St. NW Wash., D.C.

J W H

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3912

## CERTIFICATE OF DEATH

215

Reg. Dist. No. ....

1. PLACE OF DEATH. COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital		STREET ADDRESS 1803 Cody Drive	
3. NAME OF DECEASED (Type or Print) Jeffrey		4. DATE OF DEATH April 2, 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Mar 31, 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
13. FATHER'S NAME James T. HUGHES		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? US	
16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT AND ADDRESS Father: James T. HUGHES	
18. MEDICAL CERTIFICATION Same as item # 2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>76005 Immediate cause (a) <i>Subarachnoid Hemorrhage</i></p> <p>160a Antecedent cause(s) Diseases or conditions, if any, (b) <i>Prematurity</i> giving rise to the above cause stating the <u>underlying cause last</u></p> <p>160a (c)</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar 31, 1951, to Apr 2, 1951, that I last saw the deceased alive on Apr 2, 1951, and that death occurred at 7:55 P.m., from the causes and on the date stated above. SIGNATURE <i>A. Gedarovich</i> (Degree or title) ADDRESS DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) Disposition		DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State) U.S. Naval Medical Sch., Bethesda, Maryland	
DATE REC'D BY LOCAL REG. No. <i>Apr 3, 1951</i>		REG. No. <i>Edal Whittington</i> 24. FUNERAL DIRECTOR ADDRESS None	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Takoma Park</u>		12 days		TOWN <u>Silver Spring</u>		STREET (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium &amp; Hospital</u>		ADDRESS <u>411 Ellsworth Drive</u>		ADDRESS		ADDRESS	
3. NAME OF DECEASED (Type or Print) <u>Lorraine</u>		(First) <u>Lorraine</u>	(Middle) <u>X</u>	(Last) <u>Chase</u>	4. DATE OF DEATH <u>4 29 1951</u>		(Month) <u>4</u> (Day) <u>29</u> (Year) <u>1951</u>
5. SEX <u>F.</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>2-19-67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		9. AGE last birthday <u>84</u>		If under 1 year Months <u>0</u> Days <u>0</u> If under 24 hrs. Hours <u>0</u> Min. <u>0</u>	
13. FATHER'S NAME <u>John Baker Chase</u>		14. MOTHER'S MAIDEN NAME <u>Mary Delia Sutton</u>		11. BIRTHPLACE (State or foreign country) <u>Steuben Co. - N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT AND ADDRESS <u>Mr. Clifford W. Hurley</u>		18. MEDICAL CERTIFICATION <u>411 Ellsworth Dr. Silver Spring</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <u>420.0</u>		(a) <u>Antecedent cause(s)</u>		Reute Myocardial Infarction			
Diseases or conditions, if any, giving rise to the above cause <u>93d</u>		(b) <u>stating the underlying cause last</u>		Arterio sclerotic Heart Disease			
(c)				Peritonitis			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>time</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) <u>(CITY OR TOWN)</u>		(COUNTY) <u>(COUNTY)</u> (STATE) <u>(STATE)</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-12</u> , 19 <u>47</u> , to <u>4-29</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4-28</u> , 19 <u>51</u> , and that death occurred at <u>320</u> a.m., from the causes and on the date stated above.							
SIGNATURE <u>Dean H. Harding M.D.</u>		(Degree or title) <u>113 Carroll St NW Wash DC</u>		ADDRESS <u>4-29-51</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Trans. &amp; Burial</u>		DATE THEREOF <u>5/3/51</u>		NAME OF CEMETERY OR CREMATORIAL <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) <u>Chemung County, N.Y.</u>	
DATE REC'D. BY LOCAL REG. <u>5/1/51</u>		REGISTRAR'S SIGNATURE <u>G. Nathan Dodd</u>		24. FUNERAL DIRECTOR <u>Warren &amp; Humphrey</u>		ADDRESS <u>8434 Ga. Ave., Silver Spring Maryland</u>	

RECEIVED  
APR 4 1951  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3914

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <i>Montgomery Co</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <i>TOWN</i> <i>Tokoma Park</i>		LENGTH OF STAY (in the place) <i>2 mo</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>716 Hudson St</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <i>TOWN</i> <i>Washington D.C.</i>	
STREET ADDRESS <i>1730 M St NW</i>		STREET ADDRESS <i>(If rural, give location)</i>	
3. NAME OF DECEASED (Type or Print) <i>Mary</i>	(First) <i>Mary</i>	(Middle) <i>ELLA</i>	(Last) <i>Huyck</i>
4. DATE OF DEATH <i>APRIL 21</i>	(Month) <i>APRIL</i>	(Day) <i>21</i>	(Year) <i>1951</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept 17, 1878</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Conservy</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	9. AGE last birthday <i>72</i>	11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>
13. FATHER'S NAME <i>William Oliver Bruff</i>	14. MOTHER'S MAIDEN NAME <i>Ella Chandler</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT AND ADDRESS <i>John Bruff Tokoma Park Md</i>	
18. MEDICAL CERTIFICATION			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause *Myocardial infarction due to coronary*(a) *sclerosis*

—

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last(b) *Sen. arteriosclerosis with arteriosclerosis*

3 yrs.

420.0

93d

*heart disease*

3 yrs.

(c) *Rt sided hemi-paresis*

3 yrs.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN)	(COUNTY)	(STATE)
-------------------------------------	-----------	---	----------------	----------	---------

TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
--	----	--	-----------------------	--	--

22. I hereby certify that I attended the deceased from *Nov 1948*, to *4-24-51*, that I last saw the deceased

alive on *4-20, 1951*, and that death occurred at *140 1/4 A.m.*, from the causes and on the date stated above.

SIGNATURE *John Chandler MD*(Degree or title) *ADDRESS*DATE SIGNED *4-24-51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>4/26/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Mt Olivet</i>	LOCATION (City, town, or county) <i>Washington D.C.</i>	(State)
--	-----------------------------	--	---	---------

DATE REC'D BY LOCAL REG. <i>4/26/51</i>	REGISTRAR'S SIGNATURE <i>Amelia DeGeorge</i>	24. FUNERAL DIRECTOR ADDRESS <i>Z. Gischlone Hyattsville Md</i>
--	--	--

DATE REC'D BY LOCAL REG. <i>4/28/51</i>	REGISTRAR'S SIGNATURE <i>J. Wilson Dally</i>
--	--

RECEIVED  
MAY 1 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3915

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Charles			
CITY (If outside corporate limits, write RURAL and OR give nearest town) LENGTH OF STAY TOWN Bethesda, Rural (in this place) 8 days				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Alton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS none (If rural, give location)			
3. NAME OF DECEASED (Type or Print) Robert Lee		(First) (Middle) (Last)		4. DATE OF DEATH April 13, 1951			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Aug 6, 1891	9. AGE last birthday 59	If under 1 year Months 08	If under 24 hrs. Days 08	If under 1 min. Hours 08
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY US Gov't	11. BIRTHPLACE (State or foreign country) Maryland				
13. FATHER'S NAME Matthew IRWIN		14. MOTHER'S MAIDEN NAME Elizabeth ROBEY				12. CITIZEN OF WHAT COUNTRY? US	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WWT	17. INFORMANT AND ADDRESS Brother: John S. IRWIN				
18. MEDICAL CERTIFICATION Same as item # 2							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) Ventricular fibrillation 420.1 Antecedent cause(s) (b) Myocardial infarction Diseases or conditions, if any, giving rise to the above cause 93d stating the underlying cause last (c) Arteriosclerotic Cardiovascular Disease 2 + years							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr 6, 1951, to Apr 13, 1951, that I last saw the deceased alive on Apr 13, 1951, and that death occurred at 11:20 P.m., from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED E. H. ESTES, Jr., LT JG, MCR, USNR U.S. NAVAL HOSPITAL April 14, 1951							
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Apr 17, 1951		NAME OF CEMETERY OR CREMATORIAL Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REG. Apr 14, 1951		REGISTRAR'S SIGNATURE E. H. ESTES		24. FUNERAL DIRECTOR ADDRESS W. W. Chambers, 517 11th Street, S.E., Washington, D.C. R.A.D.			

RECEIVED  
MAY 17 1951  
BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3916

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY Montgomery			MARYLAND		
CITY (If outside corporate limits, write RURAL and OR give nearest town)			LENGTH OF STAY (In this place)		
TOWN Chevy Chase					
HOSPITAL OR INSTITUTION OR STREET ADDRESS 417 Turner St.					
3. NAME OF DECEASED (Type or Print)		(First) GERTRUDE	(Middle) V. JOHNSON	(Last)	4. DATE OF DEATH April 22, 1951
5. SEX		6. COLOR OR RACE Female White	7. SINGLE, MARRIED, WIDOWED (Specify) Widowed	8. DATE OF BIRTH 29 Aug. 1874	9. AGE last birthday 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife same		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James B. Williams		14. MOTHER'S MAIDEN NAME Sarah R. Paxton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT AND ADDRESS Mrs. Carl L. Bush	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p>331X Immediate cause (a) <i>Cerebral vascular accident</i></p> <p>83a Antecedent cause(s) (b) <i>Hypertension</i></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/8, 1951, to 4/14, 1951, that I last saw the deceased alive on 4/14, 1951, and that death occurred at 7P.m., from the causes and on the date stated above.					
SIGNATURE (Degree or title) ADDRESS DATE SIGNED					
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 4-25-1951		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) Elbrook Church Cem. Washington, D. C.	
DATE REC'D BY LOCAL REG. 4-23-51		REGISTRAR'S SIGNATURE Helen L. Elsmelder		24. FUNERAL DIRECTOR Robert A. Humphrey	
				ADDRESS Bethesda, Md.	

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

VS. A15

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APR 24 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3917

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Seafordville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Seaford</i> , Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET (If rural, give location) ADDRESS <i>101 W. Island St.</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>MAESTHALL</i>	(Middle) <i>H.</i>	(Last) <i>JONES</i>
4. SEX <i>Male</i>	5. COLOR OR RACE <i>White</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	7. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>
8. DATE OF BIRTH <i>Nov. 13, 1871</i>	9. AGE last birthday 90 yrs.	10. If under Months. <i>80.</i>	11. If under 24 hrs. Days <i>0.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	11. BIRTHPLACE (State or foreign country) <i>Stateville, Penna</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Jones</i>	14. MOTHER'S MAIDEN NAME <i>Rebecca Marshall</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>
17. INFORMANT AND ADDRESS <i>Roger Whitelord</i>	18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>1 mo. knows</i>	19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>Reported &amp; taken care of</i>

20. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <i>600.0</i>	(a) <i>Severe Pyelonephritis</i>	21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
Antecedent cause(s) <i>133a</i>	(b) <i>Pyelonephritis</i>	TIME (Month) (Day) (Year) (Hour) OF INJURY <i>m.</i>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	22. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

23. BURIAL, CREMATION REMOVAL (Specify) <i>Cremation</i>	DATE <i>Apr. 8, 1951</i>	NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Seafordville, Seaford, Penna.</i>
DATE REC'D BY LOCAL REG. REG. <i>April 9, 1951</i>	REGISTRAR'S SIGNATURE <i>Frances Deller</i>	24. FUNERAL DIRECTOR ADDRESS <i>Robert A. Pennington, Bethesda, Md.</i>

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1957

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

3918

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Montgomery MARYLAND		Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Bethesda, Rural LENGTH OF STAY in this place		TOWN Bethesda,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital		STREET ADDRESS 4504 Jones Bridge Road (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH April 22, 1951	
(First) Raymond		(Middle) Crawford	
(Last) KARGE		5. SEX Male	
6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Aug 29, 1895		9. AGE last birthday 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not known		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George KARGE		14. MOTHER'S MAIDEN NAME Elizabeth McGINNIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Wife: Laura R. KARGE		18. MEDICAL CERTIFICATION Same as item # 2	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Myocardial Infarctions - Multiple 3 yrs			
Antecedent cause(s) (b) Coronary Occlusions - Multiple 3 yrs			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Atherosclerotic HT. Disease 20 yrs			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Hepat & Pulmonary Congestion 2 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Apr 16, 1951, to Apr 22, 1951, that I last saw the deceased alive on Apr 22, 1951, and that death occurred at 1:10 P.m., from the causes and on the date stated above. SIGNATURE <i>S. M. Fox, Jr.</i> (Degree or title) ADDRESS DATE SIGNED U.S. NAVAL HOSPITAL April 23, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Apr 25, 1951	
DATE REC'D BY LOCAL REG. Apr 23, 1951		REGISTRAR'S SIGNATURE <i>Each Whittington</i>	
24. FUNERAL DIRECTOR		ADDRESS R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.	

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APR 24 1951  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

3919

1. PLACE OF DEATH COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Wash.</i> COUNTY <i>D.C.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Washington</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Washington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>R.F.D. #3</i>		STREET ADDRESS <i>15 E ST. N.W.</i>	
3. NAME OF DECEASED (Type or Print) <i>Mary Margaret N. M. Keogh</i>	(First) <i>Mary</i>	(Middle) <i>Margaret</i>	(Last) <i>Keogh</i>
4. DATE OF DEATH <i>April 12, 1951</i>	(Month)	(Day)	(Year)
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>3/11/1869</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Book keeper</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>D.C. schools</i>	11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>John M. Keogh</i>	14. MOTHER'S MAIDEN NAME <i>Alice</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <i>Washington, D.C. D. Hopkins, 3059 Glenmont St.</i>	
18. MEDICAL CERTIFICATION			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause *Coronary Occlusion*

(a)

8 days

Antecedent cause(s) *Hypertension*Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(b)

years

94a

(c) *Generalized arteriosclerosis*

years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

*None*

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month)	(Day)	(Year)	INJURY OCCURRED While at	HOW DID INJURY OCCUR?	
OF INJURY	m.		Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		

22. I hereby certify that I attended the deceased from *Feb. 6, 1950 to April 12, 1951*, that I last saw the deceased alive on *April 12, 1951*, and that death occurred at *6:30 p.m.*, from the causes and on the date stated above.

SIGNATURE *John M. Keogh*(Degree or title) *1007 Seminary Rd.*DATE SIGNED *April 13, 1951*

23. BURIAL, CREMATION REMOVAL (Specify) <i>4-14-51</i>	BATE THEREOF <i>4-14-51</i>	NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Washington Memorial Park</i>	(State) <i>D.C.</i>
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DATE REC'D BY LOCAL REG. <i>April 13/51</i>	REGISTRAR'S SIGNATURE <i>Frances Potter</i>	24. FUNERAL DIRECTOR ADDRESS <i>6217 18th St. N.W. 2901-1815</i>
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APR 16 1951

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3920

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) (In this place)			CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Chevy Chase			TOWN Chevy Chase		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6969 Brookville Road			STREET ADDRESS 6969 Brookville Road (If rural, give location)		
3. NAME OF DECEASED (First) (Middle)		(Last)		4. DATE OF DEATH April 20, 1951 19	
(Type or Print) MRS. ANNUNCIATA DARTON		KERLIN			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 31, 1905	9. AGE last birthday 45 yrs.	If under 1 year Months 8 Days 19 Hours 10 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Laramie, Wyoming		
13. FATHER'S NAME Nelson H. Darton		14. MOTHER'S MAIDEN NAME Alice W. Wasserbach			12. CITIZEN OF WHAT COUNTRY U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			17. INFORMANT AND ADDRESS Chevy Chase, Md William J. Kerlin, 6969 Brookville Rd

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

7 days

Immediate cause

(a) General Viral Failure  
Cirrhosis of the Liver

581.0 Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b)

50

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

Carcinoma of the Breast

8 months

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)	
INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>				
TIME (Month)	(Day)	(Year)	(Hour)	HOW DID INJURY OCCUR?		
OF INJURY	m.					

22. I hereby certify that I attended the deceased from Aug. 1, 1950, to April 20, 1951, that I last saw the deceased  
alive on April 20, 1951, and that death occurred at 5:45 P.M., from the causes and on the date stated above.  
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
4/23/51	4/23/51	Mt. Olivet Cem.	11/15/51 Washington, D.C.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
Apr 23/51	Frances T. Sharpe	Joseph Gawler's Sons 1756 Pa. Ave Washington, D. C.		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

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APR 25 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3921

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

223-

1. PLACE OF DEATH. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Fooda Maryland</u> COUNTY <u>YONCE GEORGES</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Tape, Pk</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>South Engle</u> <u>Hyatt's villa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San + Hospital</u>		STREET ADDRESS <u>4003 Quintana st.</u>			
3. NAME OF DECEASED (Type or Print) <u>LENORA</u>		(First) <u>BLANCHE</u> (Middle) <u>KLEIN</u> (Last)		4. DATE OF DEATH <u>4 19 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>9-17-76</u>	9. AGE last birthday <u>74</u> yrs.	If under 1 year Months. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>Amer.</u>
13. FATHER'S NAME <u>Emmanuel Stoner</u>		14. MOTHER'S MAIDEN NAME <u>Maria Royer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>260X</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT AND ADDRESS <u>Mrs. Vera Woods (same) daughter</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cerebral hemorrhageINTERVAL BETWEEN  
ONSET AND DEATH

hours

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause lastdiabetes mellitus, coronary insufficiency

2 years

(b) obesity, arteriosclerosis generalized

years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day) (Year) m.	(Hour) While at Work	INJURY OCCURRED Not While At work	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 8/18, 1949, to 4/19, 1957, that I last saw the deceasedalive on 4/18, 1951, and that death occurred at 7:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Frederick Remmald M.D. Takoma Park4/19/57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>4/19/57</u>	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>4-10-57</u>	REGISTRAR'S SIGNATURE <u>J. Wm. Dodd</u>	24. FUNERAL DIRECTOR ADDRESS <u>Cherry Chase 5101 Wisc. N.W. General Home Wash. D.C.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3922

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>Montgomery Co</u> CITY <u>Philadelphia Ave</u> TAKOMA PARK TOWN <u>Takoma Park MD</u> STREET ADDRESS <u>11 Philadelphia St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>not known</u> CITY <u>unable to learn</u> COUNTY <u>Unknown</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park MD</u>		LENGTH OF STAY (in this place) <u>2 yrs 11 mos</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lulu</u>	(Middle) <u>Mae</u>	(Last) <u>KLINE</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>19</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>unable to learn this</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper work. Selling Pictures Ency dealer from house to house</u>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>70 yrs.</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Jones</u>	14. MOTHER'S MAIDEN NAME <u>Unknown by her son</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT <u>Hanson M E Kline 625 Market St, San Francisco Calif</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause <u>9229</u> (a) <u>Right side pneumonia, probably from aspiration of mucus</u> INTERVAL BETWEEN ONSET AND DEATH <u>Apr 17 to Apr 19, 1951</u>  Antecedent cause(s) <u>195d</u> (b) <u>Paralysis of arm &amp; leg in 1946. Fractured rt thigh in Dec '47</u> Diseases or conditions, if any, <u>In over a year she has had to be fed with care art by art &amp; totally unable to speak</u> giving rise to the above cause stating the underlying cause last  (c) <u>Paralysis of vocal &amp; swallowing muscles in Feb 1950 becoming worse in 2nd episode</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>See (c) above</u>			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>—</u>	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
21. ACCIDENT SUICIDE HOMICIDE <u>No</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>—</u>	(CITY OR TOWN) <u>—</u>	(COUNTY) <u>—</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> <u>in 1933-1934-1935</u>	HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>Sept 16</u> , 1951, to <u>Apr 19</u> , 1951, that I last saw the deceased alive on <u>Apr 19</u> , 1951, and that death occurred at <u>12:27 p.m.</u> , from the causes and on the date stated above. SIGNATURE <u>G. J. P. Barger MD</u> DATE SIGNED <u>Apr 16, 1951</u>			
23. BURIAL/CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>Apr 16, 1951</u>	NAME OF CEMETERY OR Crematory <u>Forest Haven</u>	LOCATION (City, town, or county) <u>Washington</u> (State) <u>D.C.</u>
DATE REC'D BY LOCAL REG <u>4-1951</u>	REGISTRAR'S SIGNATURE <u>John Doh</u>	24. FUNERAL DIRECTOR <u>Deal Funeral Home</u>	ADDRESS <u>4812 Georgia Ave NW 11</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3923

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Virginia		COUNTY Alexandria	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda, Rural		LENGTH OF STAY (In this place) 4 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Alexandria		(If rural, give location) STREET ADDRESS 522 Bertland Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital							
3. NAME OF DECEASED (Type or Print) June (First) (none) (Middle) (Last) KNIGHT				4. DATE OF DEATH April 17, 1951		(Month) (Day) (Year)	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Apr 14, 1951	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		9. AGE last birthday 00 yrs. 00 mos. 04 days 04 hrs. 00 min.	
13. FATHER'S NAME James D. KNIGHT				14. MOTHER'S MAIDEN NAME Sarah T. JODOIN		12. CITIZEN OF WHAT COUNTRY? US	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT AND ADDRESS Mother: Sarah T. KNIGHT			
18. MEDICAL CERTIFICATION Same as item # 2							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
776X 159		Immediate cause (a) _____ Antecedent cause(s) Diseases or conditions, if any, (b) _____ giving rise to the above cause stating the underlying cause last (c) _____		Congenital Heart Immaturity Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr. 14, 1951, to Apr. 17, 1951, that I last saw the deceased alive on Apr. 17, 1951, and that death occurred at 3:31 P.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED T. W. SEDERSTROM, LT, MC, USN U.S. NAVAL HOSPITAL April 19, 1951							
23. BURIAL, CREMATION REMOVAL (Specify) Disposition		DATE THEREOF Apr 19, 1951		NAME OF CEMETERY OR CREMATORIAL U.S. Naval Medical School, Bethesda, Maryland.		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REC Apr 19, 1951		REGISTRAR'S SIGNATURE Evel Whitington		24. FUNERAL DIRECTOR None		ADDRESS	

RECEIVED

APR 20 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3924

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED. CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS	
MONTGOMERY MARYLAND BETHESDA, MD.		MONTGOMERY MARYLAND BETHESDA 5605 ROOSEVELT ST.	
3. NAME OF DECEASED (Type or Print)	(First) <i>Hubert</i>	(Middle) <i>Lee</i>	(Last) <i>Joe Jr.</i>
4. DATE OF DEATH	(Month) <i>4</i>	(Day) <i>12</i>	(Year) <i>1951</i>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Widowed</i>	8. DATE OF BIRTH
MALE	WHITE	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Greeter</i>	10b. KIND OF BUSINESS OR INDUSTRY
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Greeter</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Milton N.J.</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>James Lee</i>	14. MOTHER'S MAIDEN NAME <i>Lee</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <i>Hubert Lee Jr., 1909 Roosevelt St., Bethesda, Md.</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) <i>Myocardial failure with pulmonary edema</i> 3 days</p> <p>Antecedent cause(s) (b) <i>due to myocardial degeneration &amp; right bundle branch block</i> 5 yrs.</p> <p>186a Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <i>Benign Prostatis with partial bladder obstruction</i> 1 yr.</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Arteriosclerosis, generalized</i>			
19a. DATE OF OPERATION <i>2-9-51</i>	19b. MAJOR FINDINGS OF OPERATION <i>Inter trochanteric fracture rt. hip</i>		
21. ACCIDENT (Specify) <i>Home</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>Home</i>	(CITY OR TOWN) <i>Bethesda</i>	(COUNTY) <i>Mont.</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2 8 51 10a.m.</i>	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>Slipped on ice &amp; fell</i>	
22. I hereby certify that I attended the deceased from <i>Nov.</i> 1950, to <i>April 12 1951</i> , that I last saw the deceased alive on <i>4-11-51</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Stewart Glass</i>	(Degree or title) <i>M. D.</i>	ADDRESS <i>3921 Ingomes St. N.W.</i>	DATE SIGNED <i>4-12-51</i>
23. BURIAL, CREMATION REMOVAL (Specify) <i>Cremation</i>	DATE THEREOF <i>14 Apr 1951</i>	NAME OF CEMETERY OR CREMATORIY <i>Cedar Hill Crematory</i>	LOCATION (City, town, or county) (State) <i>Suitland Md.</i>
DATE REC'D BY LOCAL REG. <i>4-16-51</i>	REGISTRAR'S SIGNATURE <i>Helen J. Eckfelder</i>	24. FUNERAL DIRECTOR <i>Robert L. Murphy</i>	
ADDRESS <i>Bethesda, Md.</i>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 17 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3925

## CERTIFICATE OF DEATH

214

Reg. Dist. No.....

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS	
TOWN		8mo. 25 days		TOWN		If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Brooke Grove Farm Convalescent Home -		Washington -		Kenasaw Apt.	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
Female	Julia	H	Waskay	Apr.	22	1957	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	If under 24 hrs. Days	If under Hours Min.
	White	Single -	Oct. 10, 1860	91	yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Teacher + Librarian				Washington D.C.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Richard Waskay		Julia Fay Hunt					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			
No				Mr. Richard L. Underwood		Nephew	

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a).....

Hemorrhia

INTERVAL BETWEEN  
ONSET AND DEATH

1 mo.

443X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

93d stating the underlying cause last

Hypertensive Cardiovascular Disease

years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>			

TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	HOW DID INJURY OCCUR?
--	----	-----------------------

22. I hereby certify that I attended the deceased from 9/9, 1950, to 4/22, 1951, that I last saw the deceased

alive on 4/20, 1951, and that death occurred at 11:10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

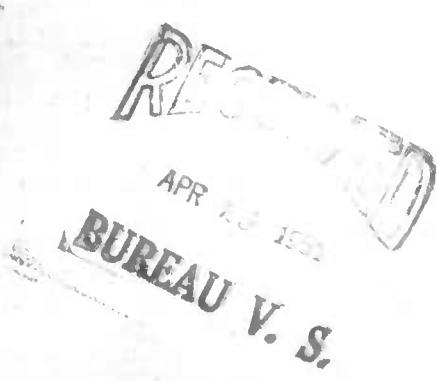
ADDRESS

DATE SIGNED

4/23/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
Burial	4/25/51	Mt. Oliver Cemetery	Washington	DC

DATE REC'D BY LOCAL REG.	REG.	REG.	REG.	REG.
April 23/51	Frances Fetter	The S. H. Fines Co.	2901-17 St. 21th.	ADDRESS



## CERTIFICATE OF DEATH

Reg. Dist. No.

24

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

<b>1. PLACE OF DEATH:</b> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda</u> LENGTH OF STAY (in this place) <u>13 1/2 hrs.</u>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u> STREET ADDRESS <u>9503 Millstead Drive</u>		
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Theresa Claire Leahy</u>			<b>4. DATE OF DEATH</b> (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1951</u>		
<b>5. SEX</b> <u>7</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>10-25-07</u>	<b>9. AGE last birthday</b> <u>43</u> yrs.	If under 1 year Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Suburban Hospital</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Plainfield, N.J.</u>		
<b>13. FATHER'S NAME</b> <u>John J. Leahy</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		
<b>15. WAS DECREASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>165-76-51</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Dooley</u>		
<b>17. INFORMANT AND ADDRESS</b> <u>Mac Leahy - 375 76th St., Brooklyn, N.Y.</u>			<b>18. MEDICAL CERTIFICATION</b>		
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>					
<b>Immediate cause</b> <u>Cardiac Decomposition</u> <b>Antecedent cause(s)</b> <u>Rheumatic Heart Disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>958</u>					
<b>Interval Between Onset and Death</b> <u>2 yrs?</u> <u>20 years</u>					
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.					
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>21. ACCIDENT</b> (Specify) <u>SUICIDE</u> <b>HOMICIDE</b>		<b>PLACE</b> (Home, farm, factory, street, of office bldg., etc.) <u>INJURY</u>		<b>(CITY OR TOWN)</b> <u>(COUNTY)</u> <u>(STATE)</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? ADDRESS	
<b>22. I hereby certify that I attended the deceased from</b> <u>April 10, 1951</u> , to <u>Same</u> , 19....., that I last saw the deceased alive on <u>April 10, 1951</u> , and that death occurred at <u>9:00</u> a.m., from the causes and on the date stated above. <b>SIGNATURE</b> <u>Theresa J. Gadalow D.</u> <b>ADDRESS</b> <u>8016 1/2 Lexington Rd.</u> <b>DATE SIGNED</b> <u>April 10, 1951</u>					
<b>23. BURIAL, CREMATION REMOVAL</b> (Specify) <u>Burial - Direct</u>		<b>DATE THEREOF</b> <u>4/11/51</u>		<b>NAME OF CEMETERY OR CREMATORIAL</b> <u>G. Johnson</u> <b>LOCATION (City, town, or County)</b> <u>Bronxdale, New York.</u> <b>(State)</b>	
<b>DATE REC'D BY LOCAL REG.</b> <u>4/11/51</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Frances Potter</u>		<b>24. FUNERAL DIRECTOR</b> <u>Robert A. Humphrey - Beth. Ind.</u> <b>ADDRESS</b>	

RECEIVED  
APR 12 1951  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3927

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Montgomery MARYLAND		Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
Washington San Ed Hosp. Takoma Park Md		Silver Springs (If rural, give location) 8318 - 16 St.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Lorick		(Month) 4 (Day) 10 (Year) 1951	
(Middle) Pierce		(Last) Miles	
5. SEX		6. COLOR OR RACE	
Male		White	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Broker		Real Estate	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
Jesse V. Miles		Greensboro Ala.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
None		?	
17. INFORMANT AND ADDRESS		12. CITIZEN OF WHAT COUNTRY	
Hospital Records.		USA	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Uremia			
181X Antecedent cause(s) (b) Carcinoma of Penis			
Diseases or conditions, if any, giving rise to the above cause 528 stating the underlying cause last (c) Carcinoma of Bladder			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
(Specify)		(CITY OR TOWN)	
INJURY		(COUNTY)	
(STATE)		20. AUTOPSY?	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 6, 1947, to April 10, 1951, that I last saw the deceased			
alive on April 10, 1951, and that death occurred at 11:15 a.m., from the causes and on the date stated above.			
SIGNATURE		(Degree or title) ADDRESS DATE SIGNED	
D. C.		1835 EYEST NW April 11, 1951	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
BURIAL		4-12-1951	
NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)	
Rock Creek Cem.		WASH - D.C.	
(State)		110744 D.C.	
DATE REC'D BY LOCAL REG. 4/12/51		REGISTRAR'S SIGNATURE	
VS A-5		24. FUNERAL DIRECTOR	
Joseph Lamberson 1756 P. St. N.W.		ADDRESS	
Weber			

RECEIVED

APR 16 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3928

218

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		BROOKVILLE MONTGOMERY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		MARYLAND MONTGOMERY	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) JEFF (Middle) - (Last) LIVESAY		4. DATE OF DEATH		(Month) APRIL	(Day) 10 (Year) 1951
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH MAY 4, 1867	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY FARMER hand - day labour		9. AGE last birthday 83 yrs.		If under 1 year Months	If under 24 hrs. Days Hours Mins.
13. FATHER'S NAME JEFF LIVESAY		11. BIRTHPLACE (State or foreign country) HANCOCK COUNTY - TENN		12. CITIZEN OF WHAT COUNTRY U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME CHARLOTTE LAMB			
17. INFORMANT AND ADDRESS BONNIE JAMES		18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause 442X Antecedent cause(s) 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		19. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 5 yrs. 1 yr.	
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
m.		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from DEC. 1950, to APRIL 10, 1951, that I last saw the deceased alive on APRIL 10, 1951, and that death occurred at 1:25 P.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED Ralph L. Nicholson, M.D. Damascus, Maryland 4/10/51							
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE April 13, 1951		NAME OF CEMETERY OR CREMATORIAL Baptist Lisbon		LOCATION (City, town, or county) Howard Co MD (State)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 4/13/51		REGISTRAR'S SIGNATURE Louis D. Bell		24. FUNERAL DIRECTOR Roy W Barber Loxmontville		ADDRESS 820105 MD	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3921

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Montgomery		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
Obey		12 days	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
Montgomery County General Hospital, Inc.		Vineyard Road	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Cora		(Month) (Day) (Year)	
(Middle) J.		April 22 1951	
5. SEX		6. COLOR OR RACE	
Female		White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
Married		April 10, 1874	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		9. AGE last birthday	
Housewife		77 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Home		Sweden	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
August Johnson		Marieida ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		none	
17. INFORMANT AND ADDRESS			
Bertha Carter (daughter) Dayton, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Cachexia			
Antecedent cause(s) (b) adenocarcinoma of the left breast with metastases			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 18 months			
50			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
April 15, 1950		adenocarcinoma of the left breast	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
(Specify)		INJURY	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF INJURY		While at Work <input type="checkbox"/> At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 23, 1946, to April 22, 1951, that I last saw the deceased			
alive on April 21, 1951, and that death occurred at 10 <sup>00</sup> m., from the causes and on the date stated above.			
SIGNATURE		(Degree or title) ADDRESS DATE SIGNED	
T Charles S. Whitaker, M.D.		Clarksville, Md. April 22, 1951	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)	
Burial		April 24, 1951 Westwood Cemetery Glenelg, Maryland	
DATE REC'D BY LOCAL REG. 4-22-57		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		ADDRESS	
Burke B. Lawler		F.C. Higgins & Son, Elliott City, Md.	

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APR 27 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3930

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Bethesda</i>		LENGTH OF STAY (in this place) <i>6 days</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hospital</i>		STREET ADDRESS <i>4622 Ellicott St. N.W.</i>	
3. NAME OF DECEASED (Type or Print) <i>William</i>		(First) (Middle) (Last) <i>hee Loudermilk</i>	
4. DATE OF DEATH <i>April 9 1951</i>	(Month)	(Day)	(Year)
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i></i>	8. DATE OF BIRTH <i>June 26 1879</i>
9. AGE last birthday <i>77 yrs.</i>	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stonecutter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Columbus Loudermilk</i>	14. MOTHER'S MAIDEN NAME <i>Mary Casteel</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i></i>	
16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT AND ADDRESS <i>Claudia Wagner - 4323 River Rd. N.W.</i>	18. MEDICAL CERTIFICATION <i>Pulmonary edema</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>443</i>	(a) <i>Antecedent cause(s)</i>	<i>Chronic Hypertension heart disease</i>	
Diseases or conditions, if any, giving rise to the above cause <i>93d</i>	(b) <i>stating the underlying cause last</i>	<i>Generalized arteriosclerosis</i>	
(c) <i>None</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i></i>	19b. MAJOR FINDINGS OF OPERATION <i></i>	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
21. ACCIDENT SUICIDE HOMICIDE <i></i>	(Specify) PLACE (Home, farm, factory, street, OF INJURY <i></i>	(CITY OR TOWN) <i></i>	(COUNTY) <i></i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i></i>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> <i></i>	HOW DID INJURY OCCUR? <i>On 15-08 Apr 9 51</i>	
22. I hereby certify that I attended the deceased from <i>alive on Apr 9 51</i> , and that death occurred at SIGNATURE (Degree or title) <i>Frances Teller</i> ADDRESS DATE SIGNED <i>7:26 P.M.</i> <i>Apr 9 51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i></i>	DATE THEREOF <i>April 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Lincoln</i>	LOCATION (City, town, or county) <i>Bladensburg Md.</i>
DATE REC'D BY LOCAL REG. <i>4/11/51</i>	REGISTRAR'S SIGNATURE <i>Frances Teller</i>	24. FUNERAL DIRECTOR <i>Cherry</i>	ADDRESS <i>Cherry Chappell 3101 N.W. 11th St. Funeral Home 5840000</i>

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APR 12 1951  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3931

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Mont.</u>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda</u> LENGTH OF STAY (in this place) <u>5 da.</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>			STREET ADDRESS <u>8801 Ridge Road</u>		
3. NAME OF DECEASED (Type or Print) <u>Margaret</u>		(First) <u>Ida</u> (Middle) <u>Young</u> (Last)	4. DATE OF DEATH <u>April 7</u>		(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb. 3, 1880</u>	9. AGE last birthday <u>71</u>	If under 1 year yrs. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>James M. Young</u>		14. MOTHER'S MAIDEN NAME <u>Mary Robinson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>151-46-85</u>	
17. INFORMANT AND ADDRESS <u>Son -</u>		18. MEDICAL CERTIFICATION			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cardiac DecompensationINTERVAL BETWEEN  
ONSET AND DEATH  
one week

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last(b) Carcinoma of stomachINTERVAL  
BETWEEN  
ONSET AND DEATH  
1 year?

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July 1, 1951, to April 6, 1951, that I last saw the deceased alive on April 6, 1951, and that death occurred at 11:45 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/6/51</u>	NAME OF CEMETERY OR CREMATORIAL <u>Cedar Hill Cem.</u>	LOCATION (City, town, or county) <u>Baltimore Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>4/17/51</u>	REGISTRAR'S SIGNATURE <u>Helen Durack</u>	24. FUNERAL DIRECTOR ADDRESS <u>Summers Bros. 2007 - Nichols</u>		

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BUREAU V. 4

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 277

1. PLACE OF DEATH CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY TOWN STREET ADDRESS	
Montgomery Glenelg Maryland Glenelg Montgomery Co. Md.		Maryland Boulders Brooksville Md. (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Sammie L. Luther		4/ 22 1977	
5. SEX		6. COLOR OR RACE	
M		W	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
Waitress		Single	
10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Child		04-26-1949	
13. FATHER'S NAME		9. AGE last birthday	
Samuel E Luther		1 under 1 year Months Days Hours Min.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		11. BIRTHPLACE (State or foreign country)	
No		Maryland	
16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
no		United States	
17. INFORMANT AND ADDRESS		14. MOTHER'S MAIDEN NAME	
Mr. S. E. Luther		Roderick E. Monroe	

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

### INTERVAL BETWEEN ONSET AND DEATH

### Immediate cause

CTLY LEADING TO DEATH  
(a) General Septicemic

2 tags

### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Mycalesis pseudalexeia* ♀

### FOR SIGNIFICANT CONDITIONS

ER SIGNIFICANT CONDITIONS  
tions contributing to the death but not  
related to the disease or condition causing death

**19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION**

| 20. AUTOPSY:

21. ACCIDENT (Specify)  
SUICIDE  
HOMICIDE

PLACE (Home, farm, factory, street,  
OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  
INJURY ✓

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED  
OF  
INJURY m. While at Not While  
Work  At work  HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/22/, 1957, to 4/22, 1957, that I last saw the deceased alive on 4/22, 1957, and that death occurred at 10:10 A.M., from the causes and on the date stated above.  
SIGNATURE John B. Smith (Degree or title) Physician ADDRESS 123 Main Street DATE SIGNED 4/22/1957

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>April 25, 1951</i>	<i>Mt. Carmel</i>	<i>Montgomery Co.</i>	<i>Pa.</i>
DATE REC'D BY LOCAL REG.	REG. #	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>4-24-51</i>		<i>Gertrude B. Fowler</i>	<i>Ray W. Barden</i>	<i>Gettysburg</i>

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APR 27 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3934

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Rural - Cabin John		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Cabin John		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Cabin John	
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D #3 Bethesda, Md. Box 164		STREET ADDRESS R.F.D #3 Bethesda, Md. Box 164		STREET ADDRESS R.F.D #3 Bethesda, Md. Box 164		STREET ADDRESS R.F.D #3 Bethesda, Md. Box 164	
3. NAME OF DECEASED (Type or Print)	(First) Bernard	(Middle) I.	(Last) Marsden	4. DATE OF DEATH Apr 5 1957	(Month) Apr	(Day) 5	(Year) 1957
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 30 Oct 1895	9. AGE last birthday 55 yrs.	If under 24 hrs Months 5	If under 1 year Days 5	If under 24 hrs Hours 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY US			
13. FATHER'S NAME Franklin I. Marsden		14. MOTHER'S MAIDEN NAME Gertrude L. Hill	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Claire M. Kitchen	Same as item # 1

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

420.1

Antecedent cause(s)

94a

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(c)

INTERVAL BETWEEN  
ONSET AND DEATHFound  
dead in  
bed.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
---	---	----------------	----------	---------

TIME (Month) (Day) (Year) (Hour)  
OF INJURY      INJURY OCCURRED  
m.      While at      Not while  
work       at work 

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes  accident  suicide  homicide  undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4/8/51	NAME OF CEMETERY OR CREMATORIAL Potomac Church Cemetery	LOCATION (City, town, or county) Potomac, Maryland	(State)
--	------------------------	--	---	---------

DATE REC'D BY LOCAL REG. 4-5-51	REGISTRAR'S SIGNATURE Helen Currocks	24. FUNERAL DIRECTOR Robert A. Humphrey	ADDRESS Bethesda, Md.
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3935

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write BURAL and give nearest town) TOWN		CITY (If outside corporate limits, write BURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH	
(First) David		(Month) (Day) (Year) April 30 1957	
(Middle) Houston		(Last)	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married		8. DATE OF BIRTH 2-21-80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday 71 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Clerk - Woodward &洛夫		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Daniel Mathews		14. MOTHER'S MAIDEN NAME Lucy Charlton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. -	
17. INFORMANT AND ADDRESS Mrs. Mabel Mathews 403 Forest Glen Rd		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 35 sec	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

142.1 Immediate cause

(a) Metastatic Carcinoma Brain Stem

Antecedent cause(s)

445 Lumbar Vertebrae

548 Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

Carcinoma Parotid Gland

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

Fall 1949

Carcinoma (Mucoepidermoid) Parotid Rd.

## 20. AUTOPSY?

Yes  No 21. ACCIDENT (Specify)  
SUICIDE  
HOMICIDEPLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURYINJURY OCCURRED  
While at Work  At work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949 to April 30 1957, that I last saw the deceased

alive on April 22, 1957, and that death occurred at 6:50 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

DATE REC'D. BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-2-57 Rock Creek Washington D.C. April 30 1957

J. W. M. D. 1888-1901-19th year

1940 646

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MAY 2 1968  
FBI  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

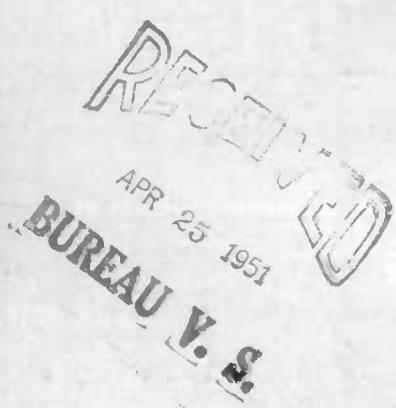
3933

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

VS. A15  
MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Gaithersburg Md 81 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Gaithersburg Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First) <i>EUGENIA</i>	(Middle) <i>MC MAHON</i>	4. DATE OF DEATH <i>Jul 26 1951</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	8. DATE OF BIRTH <i>JUNE 19 1869</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic own</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE last birthday <i>81</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Sylvester Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Mary C Bearers</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>26</i>	
17. INFORMANT AND ADDRESS <i>John MC mahon Gaithersburg</i>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <i>Cerebral hemorrhage (hemiplegia)</i>			
Antecedent cause(s) (b) <i>83a</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Hypertension</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>7-15-1951</i> , to <i>7-20-1951</i> , that I last saw the deceased alive on <i>7-20-1951</i> , and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above. SIGNATURE <i>J. Brochart M.D.</i> ADDRESS <i>Gaithersburg Md 4-23-51</i> DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Buried</i>	DATE THEREOF <i>April 24 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Forest Oak</i>	LOCATION (City, town, or county) <i>Gaithersburg Montgomery Md</i> (State)
DATE REC'D BY LOCAL REG. REG.	REGISTRAR'S SIGNATURE <i>Wendal Cooke</i>	24. FUNERAL DIRECTOR ADDRESS <i>Roy W Barber &amp; Sons</i>	



**Reg. Dist. No**

1. PLACE OF DEATH- COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>District of Columbia</b>		COUNTRY			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>TOWN Bethesda, Rural</b>		LENGTH OF STAY (In this place) <b>18 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Washington</b>		(If rural, give location) <b>1607 22nd Street, S.E.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U.S. Naval Hospital</b>				(Last) <b>MEAD</b>		4. DATE OF DEATH <b>April 22, 1951</b>			
3. NAME OF DECEASED (First) (Type or Print) <b>Leo</b>		(Middle) <b>(none)</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Jan 17, 1879</b>		9. AGE last birthday <b>72 yrs.</b>		If under 1 year Months Days Hours <b>03 05</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US Navy</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Elder MEAD</b>				14. MOTHER'S MAIDEN NAME <b>Rose HOWARD</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>SpAm. W. I &amp; II</b>		17. INFORMANT <b>Wife: Mamie MEAD</b>					
18. MEDICAL CERTIFICATION Same as item # 2								INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 hrs</b>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
Immediate cause <b>03.7</b>		(a) <b>Massive subdural &amp; subarachnoid hemorrhage, left cerebral.</b>							
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last <b>186a</b>		(b)							
		(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY Hospital</b>		(CITY OR TOWN) <b>Bethesda</b>		(COUNTY) <b>Montgomery</b>		(STATE) <b>MD</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Apr. 22, 1951 8 a.m.</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <b>Fell, striking head on floor</b>					
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .									
SIGNATURE <b>Frank J. Broschart</b>		(Degree or title) <b>M.D.</b>		ADDRESS		DATE SIGNED <b>April 23, 1951</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Apr 25, 1951</b>		NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>			
DATE REC'D BY LOCAL <b>REG. Apr 23, 1951</b>		REGISTRAR'S SIGNATURE <b>Edith Whittington</b>		24. FUNERAL DIRECTOR <b>W. W. Chambers, 517 11th Street, SE, Washington, D.C.</b>		ADDRESS <b>EDITH WHITTINGTON</b>			

MARGIN RESERVED FOR BINDING

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1951

BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Bethesda</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Bethesda</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>4512 Chestnut St, Beth.Md.</b>		STREET (If rural, give location) <b>4512 Chestnut Street</b>	
3. NAME OF DECEASED (Type or Print) <b>Marshelle C. Moler</b>	(First) <b>Marshelle</b>	(Middle) <b>C.</b>	(Last) <b>Moler</b>
4. DATE OF DEATH <b>Apr 27 1951</b>	(Month) <b>Apr</b>	(Day) <b>27</b>	(Year) <b>1951</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>25 Dec. 1897</b>
9. AGE last birthday If under 1 year Months Days Hours <b>53 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>Cab Driver</b>	11. BIRTHPLACE (State or foreign country) <b>Millville, W. Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Eugene W. Moler</b>	14. MOTHER'S MAIDEN NAME <b>Mary E. Engle</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>World War I</b>	
16. SOCIAL SECURITY NO. <b>579-221213</b>	17. INFORMANT AND ADDRESS <b>Mrs. Betty Spiker-Kearneysville.</b>	18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
120.1 94a	Immediate cause (a) <b>Coronary occlusion</b>	INTERVAL BETWEEN ONSET AND DEATH <b>sudden death</b>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)  (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . SIGNATURE <b>Frank J. Brockart M.D.</b> (Degree or title) <b>ADDRESS</b> <b>4-27-51</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>1 May 1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
DATE REC'D BY LOCAL REG. <b>4 30/5</b>	REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>	24. FUNERAL DIRECTOR ADDRESS <b>Robert A. Pumphrey-Bethesda, Md.</b>	

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MAY 2 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3938

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 211

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY			
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN			
TOWN <i>Gaithersburg (rural)</i>		<i>life</i>		<i>Gaithersburg (rural)</i>		<i>near Woodfield</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<i>near Woodfield</i>		STREET ADDRESS		<i>(Rural, give location)</i>			
3. NAME OF DECEASED (Type or Print)		(First) <i>Clifton</i>	(Middle) <i>Breast</i>	(Last) <i>Monroe</i>	4. DATE OF DEATH		(Month) <i>Apr</i>	(Day) <i>2</i>	(Year) <i>1951</i>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH		9. AGE last birthday		10. IF under 24 hrs yrs. Months Days Hours Min.	
male	col	<i>single</i>		<i>Oct 7 - 1950</i>		<i>5 - 25</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
		-		<i>Olney, Md</i>		<i>U.S.A.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECRSED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
<i>Clifton Leroy Lyles</i>		<i>Shirley Monroe</i>		(Yes, no, or unknown) <i>106c</i>		<i>106C</i>		<i>Bessie E. Monroe</i>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

501X

Immediate cause

(a) *Fracture - bronchitis*

2 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

106c

(b)

(c) *Fond deal in bed*

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at <input type="checkbox"/> Not while <input type="checkbox"/> INJURY <input type="checkbox"/> m. <input type="checkbox"/> work <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes  accident  suicide  homicide  undetermined .

SIGNATURE

(Degree or title)

ADDRESS

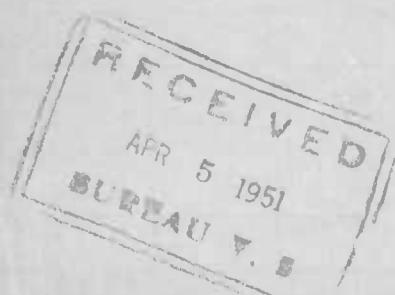
DATE SIGNED

*Frank J. Broschart, M.D.**Gaithersburg Md*

4-2-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>Apr. 4, 1951</i>	<i>Bartonsville Col. Cemetery</i>	<i>Bartonsville - MD</i>	
DATE REC'D BY LOCAL REG.	REG. <i>4/2/51</i>	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
		<i>Della N. Burdette</i>	<i>M.R. Etchison &amp; Son, Frederick</i>	<i>MD.</i>

20007014406



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3939

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY MONTGOMERY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND	
CITY (If outside corporate limits, write RURAL and OR, give nearest town) OLNEY		LENGTH OF STAY (In this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS THE MONTGOMERY COUNTY GENERAL HOSPITAL INC.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GAITHERSBURG	
3. NAME OF DECEASED (Type or Print) JAMES		(First) (Middle) MOUNT (Last)	4. DATE OF DEATH APRIL 8 1951
5. MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 10/22/1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) APRAISER		10b. KIND OF BUSINESS OR INSTITUTION ORPHANS' COURT	9. AGE last birthday 78
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN R. MOUNT		14. MOTHER'S MAIDEN NAME SUSAN MOLFORTH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS HOSPITAL RECORDS		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>Immediate cause (a) <i>J. Bilia-Cranial hemorrhage</i></p> <p>Antecedent cause(s) (b) <i>Left</i></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Arteris sclerosis</i></p> <p>83IX</p> <p>83a</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		83b	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? m. <input type="checkbox"/>
22. I hereby certify that I attended the deceased from <i>Mar. 9, 1951</i> , to <i>April 8, 1951</i> , that I last saw the deceased alive on <i>April 8, 1951</i> , and that death occurred at <i>10 p.m.</i> , from the causes and on the date stated above. SIGNATURE <i>Jack Schumacher M.D.</i> (Degree or title) <i>Gaithersburg, Md.</i> ADDRESS <i>10 p.m.</i> DATE SIGNED <i>April 8, 1951</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>4-11-51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Damascus</i>
DATE REC'D BY LOCAL REG. <i>4-10-51</i>		REGISTRAR'S SIGNATURE <i>Estherde B. Lawler</i>	LOCATION (City, town, or county) <i>Damascus, Md.</i> (State)
24. FUNERAL DIRECTOR ADDRESS		<i>Boyle &amp; Barber Laytonville</i>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

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APR 16 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3940

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Silver Spring LENGTH OF STAY (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring STREET ADDRESS 7908 Woodbury Drive (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 821 Heron Drive			4. DATE (Month) (Day) (Year) OF DEATH April 14 1951		
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) Mary E. Murphy			5. SEX Female 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home		
13. FATHER'S NAME Peter R. Campbell			11. BIRTHPLACE (State or foreign country) Lamasco, Kentucky		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			12. CITIZEN OF WHAT COUNTRY USA		
16. SOCIAL SECURITY NO.			17. INFORMANT AND ADDRESS 7908 Woodbury Drive Mr. Robert H. Murphy, Silver Spring, Maryland		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) ACUTE CONGESTIVE HEART FAILURE 2 days					
Antecedent cause(s) (b) HODGKIN'S DISEASE 3 yrs.					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) II MITRAL INSUFFICIENCY 10 yrs.					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 18</u> , 1948, to <u>April</u> , 1951, that I last saw the deceased alive on <u>April 18</u> , 1951, and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>L.G. Snow MD</u> ADDRESS <u>Silver Spring, Md.</u> DATE SIGNED <u>4-14-51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 4/16/51		NAME OF CEMETERY OR CREMATORIAL Colesville Cemetery	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		LOCATION (City, town, or county) (State) Colesville, Montgomery Co. Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR ADDRESS Warren & Murphy 8434 Ga. Ave., Silver Spring Maryland	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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APR 18 1951

BUREAU W. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

3941

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda, Rural LENGTH OF STAY (in this place) 5 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington (If rural, give location) STREET ADDRESS 2426 Iverson Street, S.E.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		4. DATE OF DEATH April 13, 1951	
3. NAME OF DECEASED (First) Charles (Middle) Robertson (Last) NOBLE		5. SEX Male	
6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Harry R. NOBLE		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? US	
16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT AND ADDRESS Father: Harry R. NOBLE	
18. MEDICAL CERTIFICATION Same as item # 2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause		(a) <i>Septicemia</i> ? <i>Staph aureus.</i> 5d	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		(b) <i>generalized neurologic dermatitis</i> 2d -	
		(c) <i>scleroderma</i> 2d	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Apr. 8, 1951, to Apr. 13, 1951, that I last saw the deceased alive on Apr. 13, 1951, and that death occurred at 1:25 A.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Apr 17, 1951 NAME OF CEMETERY OR CREMATORIAL Arlington National LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REG Apr 14, 1951		REGISTRAR'S SIGNATURE	
		24. FUNERAL DIRECTOR ADDRESS R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.	

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APR 17 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3942

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Olney		LENGTH OF STAY (in this place)	one day	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County General Hospital, Inc.				STREET ADDRESS Rt. 3 (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Ettie	(Middle)	(Last) Noland	4. DATE OF DEATH April 19	(Month) (Day) (Year) 1951
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 1895-66	9. AGE last birthday 66 yrs.	10. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Halah McAbee		14. MOTHER'S MAIDEN NAME Sophie Sedgwick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS Hospital record	
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause

(a)

Acute myocarditis

3 days

431X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-16, 1951, to 4-19, 1951, that I last saw the deceased

alive on 4-19, 1951, and that death occurred at 6:55 P.m., from the causes and on the date stated above.  
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL Specify	DATE THEREOF April 23, 1951	NAME OF CEMETERY OR CREMATORIAL Emery Grove	LOCATION (City, town, or county) Towson
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE Gertrude B. Lawler	24. FUNERAL DIRECTOR Robert Snowley	ADDRESS 7208 36th Street

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APR 27 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3943

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MARYLAND</u>		COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>BETHESDA</u>		LENGTH OF STAY (In this place) <u>25 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BETHESDA</u>		(If rural, give location) STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VISITATION CONVENT</u>							
3. NAME OF DECEASED (Type or Print)	(First) <u>SISTER M.</u>	(Middle) <u>ELIZABETH</u>	(Last) <u>PEDERZINI</u>	4. DATE OF DEATH	(Month) <u>APRIL</u>	(Day) <u>28</u>	(Year) <u>1951</u>
5. SEX	6. COLOR OR RACE <u>FEMALE</u> <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>12/8/62</u>	9. AGE last birthday <u>88</u> yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RELIGIOUS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CATHOLIC NUN</u>	11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ANGELO PEDERZINI</u>		14. MOTHER'S MAIDEN NAME <u>ELISA TOMASONI</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT AND ADDRESS <u>CONVENT RECORDS</u>			
18. MEDICAL CERTIFICATION							

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause (a) Heart FailureChronic  
10 year443X Antecedent cause(s)  
Diseases or conditions, if any, (b)  
giving rise to the above cause  
stating the underlying cause last  
93d (c) Hypertension Heart Disease

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify) <u>No</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day) (Year)	(Hour) m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 1, 1951, to April 28, 1951, that I last saw the deceasedalive on April 27, 1951, and that death occurred at 7:00 P.m., from the causes and on the date stated above.  
SIGNATURE Michael J. M. Jersey, M.D. ADDRESS 1150 Connecticut Avenue, N.W., Wash. D.C. DATE SIGNED 4-28-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>APRIL 30/51</u>	NAME OF CEMETERY OR CREMATORIUM <u>CONVENT CEMETERY</u>	LOCATION (City, town, or county) <u>BETHESDA</u>	(State) <u>MARYLAND</u>
DATE REC'D BY LOCAL REG. <u>4-29-51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Brancis Collins</u>	ADDRESS <u>3821 14th N.W. Wash. D.C.</u>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3944

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <i>Maryland</i> COUNTY <i>Montgomery</i>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Silver Spring</i>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Silver Spring</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9319 Caroline Ave.			STREET ADDRESS <i>9319 Caroline Ave.</i>		
3. NAME OF DECEASED (Type or Print) <i>DARLEEN</i>		(First) <i>DARLEEN</i> (Middle) <i>LILLIAN</i> (Last) <i>PISANI</i>	4. DATE OF DEATH <i>April 1, 1951</i>		(Month) <i>April</i> (Day) <i>1</i> (Year) <i>1951</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Own home</i>	8. DATE OF BIRTH <i>Aug. 19, 1907</i>	9. AGE last birthday <i>43</i>	If under 1 year Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		
13. FATHER'S NAME <i>Charles Gohr</i>			11. BIRTHPLACE (State or foreign country) <i>Dodge, Nebraska</i>		
15. WAS DECRAVED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
16. SOCIAL SECURITY NO. <i>none</i>			17. INFORMANT AND ADDRESS <i>Silver Spring, Md.</i> <i>Mr. Ralph M. Pisani, 9319 Caroline Ave.</i>		

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause *175X*(a) *carcinomatosis*

3 years

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last  
*49a*(b) *Malignant granulomatous  
tumor of ovaries (Bilateral)*

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION <i>1948</i>	19b. MAJOR FINDINGS OF OPERATION <i>Bilateral malignant tumor of ovaries metastasis</i>			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) <i>White at Work</i>	(COUNTY) <i>Not White</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *June 1948* to *April 1951*, that I last saw the deceased alive on *April 1951*, and that death occurred at *3:30 A.M.* from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*Edward S. Wilson Jr. Md. 1801-Eye 82-N6 1951*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>April 4, 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>	LOCATION (City, town, or county) (State) <i>Prince Geo. County Md.</i>
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DATE REC'D BY LOCAL REG. <i>April 3, 1951</i>	REGISTRAR'S SIGNATURE <i>Frances Potter</i>	24. FUNERAL DIRECTOR <i>Warren L. Murphy 8434 Ga. Ave., Silver Spring Maryland</i>
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## MARYLAND STATE DEPARTMENT OF HEALTH

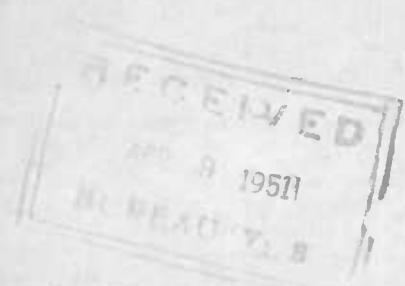
2411 N. Charles Street, Baltimore

3945

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Chevy Chase		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6800 Meadow Lane		STREET ADDRESS 6800 Meadow Lane	
3. NAME OF DECEASED (Type or Print) CHRISTINE		(First) STEVENS	(Middle) (Last) POLK
4. DATE OF DEATH April 3, 1951	(Month)	(Day)	(Year)
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 7 Dec. 1870
9. AGE last birthday 80	10. KIND OF BUSINESS OR INDUSTRY OWN Home	11. BIRTHPLACE (State or foreign country) Newton, Mass.	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Henry C. Meyer	14. MOTHER'S MAIDEN NAME Alithia Stevens		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Julia Huhsicker (same as item 1)	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) Ventricular Fibrillation - Respiratory Arrest</p> <p>439.1 Antecedent cause(s) (b) Chronic Congestive Heart Failure</p> <p>93e Diseases or conditions, if any, giving rise to the above cause (c) Glauclized Heart Failure stating the underlying cause last</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 1, 1950</u> , to <u>April 3, 1951</u> , that I last saw the deceased alive on <u>April 3, 1951</u> , and that death occurred at <u>6:35 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) Cremation	DATE THEREOF 5 Apr 1951	NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	LOCATION (City, town, or county) (State) Suitland, Maryland
DATE REC'D BY LOCAL REG. 4-4-51	REGISTRAR'S SIGNATURE Helen Kurweil	24. FUNERAL DIRECTOR Robert D. Humphrey	ADDRESS Bethesda, Md.



3946

26

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. This is especially important. Physicians: please write the causes of death clearly and legibly.

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

VS. A15

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BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3947

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>PITTSBURGH</u> COUNTY <u>ALLEGHENY</u>	
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) <u>TOWN Silver Spring</u> LENGTH OF STAY (in this place) <u>2 MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PENNSYLVANIA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3008 BLUE Ridge AVE</u>		STREET ADDRESS <u>211 - 2nd AVENUE</u>	
3. NAME OF DECEASED (Type or Print) <u>LILLIAN</u>	(First) (Middle) (Last) <u>RAWSLEY</u>	4. DATE OF DEATH <u>4 - 11 - 1951</u>	(Month) (Day) (Year)
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT. 26, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>65</u>
13. FATHER'S NAME <u>Ernest WALTER WADSWORTH</u>		11. BIRTHPLACE (State or foreign country) <u>YORKSHIRE - ENGLAND</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>DAUGHTER.</u>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>Generalized carcinomatosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>13 months</u>			
170X Antecedent cause(s) <u>CARCINOMA of LEFT BREAST - METASTASIS</u>			
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>TO LUNGS, PELVIS</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>OPERATED ON - RADICAL MASTECTOMY</u>			
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>	
20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE <u>None</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>SILVER SPRING, MONTGOMERY, MD.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>BRK</u>	
22. I hereby certify that I attended the deceased from <u>4/10/51</u> , 1951, to <u>4/11/51</u> , 1951, that I last saw the deceased alive on <u>4/10/51</u> , 1951, and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Belden R. Reap, M.D.</u>		ADDRESS <u>2601 Elnora St. Silver Spring, Md.</u> DATE SIGNED <u>4/11/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Transplant</u>		DATE THEREOF <u>4/12/51</u> NAME OF CEMETERY OR CREMATORIAL <u>Jefferson Memorial Park</u> LOCATION (City, town or county) <u>Pittsburgh, Pa.</u> (State)	
DATE REC'D BY LOCAL REG. <u>April 12, 1951</u>		REG. <u>Frances Foster</u> 24. FUNERAL DIRECTOR ADDRESS <u>W.W. Chambers &amp; Son 1400 Chapin St. N.W.</u>	
REG. <u>Frances Foster</u> ADDRESS <u>W.W. Chambers &amp; Son 1400 Chapin St. N.W.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 16 1951

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APR 16 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>		
LENGTH OF STAY (in this place)		STREET ADDRESS <u>601 E. Leland Street</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) <u>GEORGE</u>	(Middle) <u>MELBOURNE</u>	(Last) <u>ROGERS</u>	
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>12</u>	(Year) <u>1951</u>	
5. SEX	6. COLOR OR RACE <u>Male</u> <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>April 5, 1888</u> <u>1890</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Attorney</u>	11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo Rogers</u>	14. MOTHER'S MAIDEN NAME <u>Leafie Culbertson</u>	17. INFORMANT AND ADDRESS <u>Fred C. Smith, MD, 2301 Conn Ave NW, Wash., DC</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>W.W.</u>	18. MEDICAL CERTIFICATION  I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause <u>420.1</u> (a) <u>Coronary Occlusion</u> <u>8 hrs</u> Antecedent cause(s) <u>74a</u> (b) <u>Anterior Myoperfusion</u> <u>20 yrs</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cardiac enlargement</u> <u>10 yrs</u> <u>Hypertension over 20</u> <u>20 yrs</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19. DATE OF OPERATION <u>None</u> 20. AUTOPSY? <u>None</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>April 17 1951</u> <u>11:00</u>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>House</u>		
22. I hereby certify that I attended the deceased from <u>June</u> , 1951 to <u>April 17, 1951</u> , that I last saw the deceased alive on <u>April 17</u> , 1951 and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>James Hawfield, M.D.</u> ADDRESS <u>1550 Conn Ave. NW 4/17/51</u> DATE SIGNED <u>4/17/51</u>				
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>4/14/51</u>	NAME OF CEMETERY OR CREMATORIAL <u>Rock Creek Cem.</u>	LOCATION (City, town, or county) <u>WASHINGTON DC</u>	(State)
DATE REC'D BY LOCAL REG. <u>Apr 16/51</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR ADDRESS <u>Jos. Hawfield, Son, Wash. D.C.</u>		
O 55 1879				

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BUREAU W. S.



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MAY 20 1951  
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U. S. DEPARTMENT OF JUSTICE



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APR 16 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3952

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY Arlington		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda, Rural LENGTH OF STAY (in this place) 7 hours			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Arlington STREET ADDRESS 813 South Quincey Street (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital					
3. NAME OF DECEASED (Type or Print)		(First) James (Middle) Allen (Last) RUSSELL	4. DATE OF DEATH April 25, 1951		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH July 25, 1900	9. AGE last birthday 50	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Various	11. BIRTHPLACE (State or foreign country) Tennessee		
13. FATHER'S NAME William A. RUSSELL			14. MOTHER'S MAIDEN NAME Florence DAVIS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW			16. SOCIAL SECURITY NO. - - - - -		
17. INFORMANT AND ADDRESS Wife: Celia R. RUSSELL			18. MEDICAL CERTIFICATION Same as item # 2		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause (a) Rupture, Aorta Antecedent cause(s) 4431 (b) Atherosclerosis Aorta Diseases or conditions, if any, 73d giving rise to the above cause stating the underlying cause last (c) Hypertension Cardiovascular Disease  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)		(COUNTY) (STATE)
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
m.					
22. I hereby certify that I attended the deceased from Apr 25, 1951, to Apr 25, 1951, that I last saw the deceased alive on Apr 25, 1951, and that death occurred at 7:20 P.m., from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED					
J. W. FLYNN, LTJG, MC, USN U.S. NAVAL HOSPITAL April 26, 1951					
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)	
Burial	Apr 30, 1951	Arlington National	Arlington	, Virginia	
DATE REC'D BY LOCAL REG'D	REGISTER'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS			
Apr 26, 1951	Edith Whittington	W. W. Chambers, 3072 M Street, NW, Washington, D.C. 53411			

RECEIVED BY THE UNITED STATES GOVERNMENT  
CITY OF NEW YORK

RECEIVED

APR 27 1951

BUREAU V. S.



RECEIVED

MAY 10, 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3954

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>WASHINGTON D.C.</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>TAKOMA PARK</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>WASHINGTON</b>	
LENGTH OF STAY (in this place) <b>1 WEEK</b>		STREET ADDRESS <b>901 PERRY PLACE, N.E.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>EVENTIDE NURSING HOME 716 HUDSON AVE.</b>			
3. NAME OF DECEASED (Type or Print)	(First) <b>JAMES</b>	(Middle) <b>DALLAS</b>	(Last) <b>SHIRLEY</b>
4. DATE OF DEATH	(Month) <b>APRIL</b>	(Day) <b>28</b>	(Year) <b>1951</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11/30/1865</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>John H. Shirley</b>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>82</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>John H. Shirley</b>	14. MOTHER'S MAIDEN NAME <b>Unknown</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <b>42000</b>	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <b>J. Dallas Shirley (Son)</b>	18. MEDICAL CERTIFICATION <b>Uremia, Hypertonic Jaundice Generalized arteriosclerosis, myocardial tuberculosis, Leant disease</b>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause <b>Antecedent cause(s)</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>932</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Smoking</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?  DATE SIGNED	
22. I hereby certify that I attended the deceased from <b>Apr 8, 1951</b> , to <b>Apr 26, 1951</b> , that I last saw the deceased alive on <b>Apr 26, 1951</b> , and that death occurred at <b>7:35 a.m.</b> , from the causes and on the date stated above. SIGNATURE <b>H. Courtney, M.D.</b>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <b>5-1-51</b>	NAME OF CEMETERY OR CREMATORIAL <b>Harrowood Cemetery</b>	LOCATION (City, town, or county) <b>Wash D.C.</b>
DATE REC'D BY LOCAL REG. <b>4-28-51</b>	REGISTRAR'S SIGNATURE <b>J. M. M. Dodd</b>	24. FUNERAL DIRECTOR <b>The S. H. Hinrichs Co.</b>	ADDRESS <b>2401 14th St N.W. WASH. D.C.</b>

RECEIVED  
MAY 1 1951  
FBI

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

3955

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Washington</b> D.C.		COUNTY			
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR			
TOWN <b>Bethesda</b>				TOWN <b>Washington</b> , D.C.					
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<b>Leland Pharmacy</b>		STREET ADDRESS		(If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) <b>LEVIN</b>	(Middle) <b>J.</b>	(Last) <b>SOTHORON</b>	Jr.	4. DATE OF DEATH	(Month) <b>Apr</b>	(Day) <b>3</b>	(Year) <b>1951</b>
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 5 Oct 1903	9. AGE last birthday 47 yrs.	10. KIND OF BUSINESS OR INDUSTRY Drug Store-	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY US		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY US			
13. FATHER'S NAME <b>Levin J. Sothorn Sr.</b>		(Not self emp.)		14. MOTHER'S MAIDEN NAME <b>Marguerita Tayloe</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>578-01-5944</b>		17. INFORMANT AND ADDRESS <b>Martha E. Sothoron (same as item 2)</b>							

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Hemorrhage due to bullet wound  
Thor skull*

976X Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last  
164c

(b)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN  
ONSET AND DEATH

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office, bldg., etc.) INJURY <b>Pharmacy</b>	(CITY OR TOWN) <b>Bethesda</b>	(COUNTY) <b>Montgomery</b>	(STATE) <b>Md.</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Apr 3 51-6:50 p.m.</b>	INJURY OCCURRED White at work <input checked="" type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>Self-inflicted gun shot wound</i>		

22. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes  accident  suicide  homicide  undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>6 Apr 1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>Washington National</b>	LOCATION (City, town, or county) <b>Suitland</b>	(State) <b>Md.</b>
DATE REC'D BY LOCAL REG. <b>4-4-51</b>	REGISTRAR'S SIGNATURE <b>Helen Kervack</b>	24. FUNERAL DIRECTOR <b>Robert A. Humphrey - Bethesda, Md.</b>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Reg. Dist. No

214

**WRITE PLAINLY; WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Silver Spring		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8615 Piney Branch Road		STREET ADDRESS		(If rural, give location)		8615 Piney Branch Road	
3. NAME OF DECEASED (Type or Print)		(First) (Middle)		(Last)		4. DATE OF DEATH	
Samuel Greene Spear						April 27 1951	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Male		White		Married		9. AGE last birthday	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman - Consultant		10b. KIND OF BUSINESS OR INDUSTRY		July 11, 1877		73 yrs.	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY			
John Spear		Josephine Rhodes		USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS			
		022-07-5538		Mrs. Beulah B. Spear, 8615 Piney Branch Rd			
18. MEDICAL CERTIFICATION							
Silver Spring, Md							
INTERVAL BETWEEN ONSET AND DEATH							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) Coronary occlusion							
Antecedent cause(s) (b) sudden death							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
Frank J. Brochart M.D.				Gaithersburg, Md		4-27-51	
23. BURIAL, CREMATION REMOVAL (Specify) Trans. & Burial		DATE THEREOF 4/30/51		NAME OF CEMETERY OR CREMATORIAL Central Cemetery		LOCATION (City, town, or county) Milbury, Norfolk Co., Mass.	
DATE REC'D BY LOCAL REC.		REG. 4/30/51		REG. Frances Carter		24. FUNERAL DIRECTOR Warren L. Humphrey 8434 Ga. Ave., Silver Spring	
						ADDRESS Maryland	

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MAY 1 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3957

214

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D.C.		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Alta Vista Nursing Home 9200-Old Georgetown Rd.		STREET ADDRESS 1411-Brandywine St. N.W.		
3. NAME OF DECEASED (Type or Print)	(First) Annie	(Middle) L	(Last) Steidel	
4. DATE OF DEATH	(Month) 4	(Day) 24	(Year) 1951	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	
Female	White	Widowed	3-6-1870	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10h. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY	
Housewife	Home	Washington D.C.	U.S.A.	
13. FATHER'S NAME	14. MOTHER'S MIDDLE NAME			
Henry B. Stein	Mary Ellen Brown			
15. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS		
—	—	Spouse, Mrs. Gertrude Litten, 4441 Brandywine St, Washington D.C.		
18. MEDICAL CERTIFICATION				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
4500	Immediate cause	(a) Acute pulmonary edema	INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
591	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arterio-sclerosis Vascular occlusion left ankle (c) Chronic rheumatoid arthritis	10 years 48 hrs 15 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19h. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?		
—	—	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
INJURY		—	—	—
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
OF INJURY	m.	—	—	
22. I hereby certify that I attended the deceased from Dec. 5, 1938, to Apr. 24, 1951, that I last saw the deceased alive on Apr. 24, 1951, and that death occurred at 4:32 P.M., from the causes and on the date stated above.				
SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED	
Malvina W. Harrison M.D.	4135 Yuma St. N.W. Wash D.C.	4/27/51		4/27/51
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)	
Burial	4/27/51	Glenwood	Washington D.C.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
Apr. 25/51	Frances Potter	H. H. Stein, C. Washington D.C.		

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APR 27 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3958

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Virginia COUNTY King George		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN Bethesda, Rural (in this place) 22 days			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dahlgren		
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital			STREET (If rural, give location) ADDRESS 4002 4th Street		
3. NAME OF DECEASED (Type or Print)	(First) Donna	(Middle) Blanche	(Last) STEPHENSON	4. DATE OF DEATH April 30,	(Month) (Day) (Year) 19 51
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Apr 8, 1951	9. AGE last birthday 00 00 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY - - - - -	11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Daniel G. STEPHENSON			14. MOTHER'S MAIDEN NAME Irene A. VAVASIS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. - - - - -	17. INFORMANT AND ADDRESS Father: Daniel G. STEPHENSON	
18. MEDICAL CERTIFICATION Same as item # 2					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) *Immaturity*776X Antecedent cause(s)  
Diseases or conditions, if any, (b) -  
giving rise to the above cause  
stating the underlying cause last

159 (c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OCCURRED OF INJURY m.	While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? DATE SIGNED

22. I hereby certify that I attended the deceased from Apr 8, 1951, to Apr 30, 1951, that I last saw the deceased

alive on Apr 30, 1951, and that death occurred at 1:15 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

L. W. SEDERSTROM, LT, MC, USN U.S. NAVAL HOSPITAL May 1, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF May 1, 1951	NAME OF CEMETERY OR CREMATORIAL Angier Cemetery	LOCATION (City, town, or county) (State) Angier, North Car.
DATE REC'D BY LOCAL REG. May 1, 1951	REG. NUMBER E. L. Washington	24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.	

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MAY 2 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3951

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>SILVER SPRING</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>SILVER SPRING</b>		
LENGTH OF STAY (in this place) <b>8 yrs</b>		STREET ADDRESS <b>607 SCHUYLER</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>607 SCHUYLER</b>				
3. NAME OF DECEASED (Type or Print) <b>JANE FINLAYSON</b>	(First) <b>J</b>	(Middle) <b>AN</b>	(Last) <b>STEWART</b>	
4. DATE OF DEATH <b>APRIL 7 1951</b>	(Month) <b>7</b>	(Day) <b>7</b>	(Year) <b>1951</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE 14 1877</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	10c. AGE last birthday <b>73 yrs.</b>	11. BIRTHPLACE (State or foreign country) <b>BARCLAY, BIRMINGHAM, PA</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	13. FATHER'S NAME <b>ROBERT FINLAYSON</b>	14. MOTHER'S MAIDEN NAME <b>MARGARET DITCHBURN</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT AND ADDRESS <b>MR. ALEXANDER MCDONALD STEWART</b>	18. MEDICAL CERTIFICATION <b>607 SCHUYLER</b>	19. DATE OF OPERATION <b>None</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <b>CEREBRAL - COMPLETE DISSOCIATION (SECOND)</b>	(a) <b>(FIRST - FEB 16 &amp; 17<sup>th</sup>)</b>	11 HOURS		
Antecedent cause(s) <b>165X</b>	(b) <b>POLMONARY INFARCTION (FIRST)</b>	11 "		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>75C</b>	(c) <b>TERMINAL PNEUMONIA (NON-INFECTIOUS)</b>	10 "		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	" <b>PLEURISY</b> ( " " )	10 "		
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>—</b>	20. AUTOPSY?		
21. ACCIDENT SUICIDE HOMICIDE <b>NO</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>—</b>	(CITY OR TOWN) <b>—</b>	(COUNTY) <b>—</b>	(STATE) <b>—</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>—</b>	INJURY OCCURRED While at <b>—</b> m. <b>—</b>	HOW DID INJURY OCCUR? At work <input type="checkbox"/> At work <input type="checkbox"/>		

22. I hereby certify that I attended the deceased from **JAN.**, 19**51**, to **APRIL 7, 1951**, that I last saw the deceased alive on **APRIL 7, 1951**, and that death occurred at **8 A.M.** from the causes and on the date stated above.  
SIGNATURE **Blanche M. Mitchell** (Degree or title) **M.D.** ADDRESS **8055-13<sup>th</sup> ST. SILVER SPRING, MD. APRIL 7, 1951** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE <b>April 10, 1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>Morning Side Cemetery</b>	LOCATION (City, town, or county) (State) <b>Dy Bois, Prince George's Co., Md.</b>
DATE REC'D BY LOCAL REG. REG. <b>April 9, 1951</b>	REGISTRAR'S SIGNATURE <b>Frances Doctet</b>	24. FUNERAL DIRECTOR ADDRESS <b>John W. Walters, 254 Carroll St., Takoma Park, D.C.</b>	

RECEIVED

DECEMBER 11 1957

BUREAU K. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3960

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Silver Springs</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>DC</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>WASHINGTON, D.C.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1508-Ballard St.,</b>		LENGTH OF STAY (in this place)		STREET ADDRESS <b>2501-14th St NW, Washington, D.C.</b>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>Emma</b>		(First) (Middle) (Last) <b>Edmonia Stutzman</b>		4. DATE OF DEATH <b>April 1, 1951</b>		(Month) (Day) (Year)	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>June 28, 1865</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT AND ADDRESS <b>Mr. Frank Roy Stutzman-1315-K-St. NW</b>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <b>Virus Pneumonia</b>							
Antecedent cause(s) (b) <b>Arterio-venous fistula disease</b>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>8 days</b>							
93d <b>5 yrs.</b>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE <b>INJURY</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b>		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1-10, 1951</b> , to <b>3/31, 1951</b> , that I last saw the deceased alive on <b>3/31, 1951</b> , and that death occurred at <b>1:25 A.m.</b> , from the causes and on the date stated above. SIGNATURE (Degree or title) <b>Frances L. Lechner, M.D.</b> ADDRESS <b>7717 Alabama Ave. N.W. Wash. D.C.</b> DATE SIGNED <b>4-1-51</b>							
23. BURIAL OR CREMATION DEATH VENUE (Specify) <b>april 3/51</b>		DATE THEREOF <b>april 3/51</b>		NAME OF CEMETERY OR CREMATORIUM <b>Rock Creek Cemetery</b>		LOCATION (City, town, or county) <b>Washington, D.C.</b> (State)	
DATE REC'D BY LOCAL REG. <b>4/1/51</b>		REGISTRAR'S SIGNATURE <b>Frances L. Lechner</b>		24. FUNERAL DIRECTOR <b>S. H. Henrich</b>		ADDRESS <b>2901-14th St. NW</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

3961

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS			
Montgomery Maryland		Maryland Montgomery Kensington 21 Lawrence Ave.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place) Bethesda, days 56			
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)			
John R. Thompson		John R. Thompson			
4. SEX	5. COLOR OR RACE	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	7. DATE OF BIRTH		
Male	White	Single	Oct 2 1875		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR AVIATION	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY		
Silver Digger	Suburban Hospital	Maryland	U.S.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
John R. Thompson	Margaret Murphy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS			
No	None	Charles Thompson - 1120 37th St. N.W.			
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
Immediate cause		(a) Generalized arteriosclerosis, with uremia			
Antecedent cause(s)		Several years			
Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last		.			
97		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
None		.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		
None			Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY	m.				
22. I hereby certify that I attended the deceased from 4-1, 1951, to 4-8, 1951, that I last saw the deceased alive on 4-8, 1951, and that death occurred at 1:52 A.m., from the causes and on the date stated above.					
SIGNATURE	(Degree or title)		ADDRESS	DATE SIGNED	
Alan A. Dunn M.D.			Suburban Hosp. Bethesda, Md.	4-8-51	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)	
Burial	4/11/51	Union Cemetery	Burtonsville, Md.		
DATE REC'D BY LOCAL REG.	REG. 12-51	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
		Helen S. Eckendorf	Robert A. Humphrey - Bethesda, Md.	970 346	

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APR 16 1951

BUREAU V. S.



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APR 19 1952

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3963

## CERTIFICATE OF DEATH

Reg. Dist. No. 288

1. PLACE OF DEATH COUNTY			2. USUAL RESIDENCE (HOME) OF DECEASED STATE		
Montgomery MARYLAND			Maryland COUNTY		
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Gaithersburg		13 yrs	TOWN Gaithersburg		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
Asbury Methodist Home			(If rural, give location)		
3. NAME OF DECEASED (Type or Print)		(First) Sarah (Middle) Ida (Last) Tomlinson	4. DATE OF DEATH		(Month) 4 (Day) 19 (Year) 51
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday
Female		White	WIDOW	June 18/1867	83 yrs. 10, 1. 1. 1.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Housewife		III	Washington/D.C.	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John R. Reeves		Dortha McNutt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			17. INFORMANT AND ADDRESS
No					Methodist Home Records, Gaithersburg

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION		
Immediate cause (a) <i>cerebral hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH 10 days		
Antecedent cause(s) 831X 83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____ (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *April 10*, 1951, to *April 19*, 1951, that I last saw the deceased  
alive on *April 10*, 1951, and that death occurred at *11:45* a.m., from the causes and on the date stated above.

SIGNATURE		ADDRESS		DATE SIGNED
<i>William C. Miller, M.D.</i>		<i>7-Brooks Ave., Gaithersburg, Md. 20878</i>		<i>April 19, 1951</i>
23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORIAL National Memorial Park	LOCATION (City, town, or county) Falls Church Va (State)
Burial		4/21/51		
DATE REG'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	
<i>April 20, 1951</i>		<i>Abner L. Cooke</i>	ADDRESS Ernest C. Gartner, Gaithersburg, Md.	

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APR 24 1951

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Items 11, 13, 14, on:

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3964

FILE NO. G 132 APR 23 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Chevy Chase</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chevy Chase</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <i>6400 Brookville rd</i>	
3. NAME OF DECEASED (Type or Print) <i>Cora Elizabeth Troxell</i>		4. DATE OF DEATH <i>4 16 1951</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Oct 25 1865</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Govt Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Treasury Dept U.S.</i>	
13. FATHER'S NAME <i>William H. Troxell</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>1 911 2100</i>	
17. INFORMANT AND ADDRESS <i>6400 Brookville rd</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>Acute Cardiac failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>	
196 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>55b</i>		(a) <i>Adeno Cervicoma of the ribs + liver</i>	
(b) <i>stating the underlying cause last</i>		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Apr 19 1951</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Apr 19</i> , 1951, to <i>Apr 16</i> , 1951, that I last saw the deceased alive on <i>Apr 16</i> , 1951, and that death occurred at <i>1:15 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>C. W. Lulier, M.D.</i> ADDRESS <i>3781 Alvin St NW 4/16/51</i> DATE SIGNED <i>4/16/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Apr 19, 1951</i>	
DATE REC'D BY LOCAL REG. <i>April 17 1951</i>		NAME OF CEMETERY OR CREMATORIAL <i>Glenwood</i>	
REG. <i>Frances Potter</i>		LOCATION (City, town, or county) (State) <i>Washington DC</i>	
REG. <i>Frances Potter</i>		24. FUNERAL DIRECTOR ADDRESS <i>L.S. Hines Co 2901-14 1770</i>	

APR 1951  
BUREAU W. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3965

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
MONTGOMERY MARYLAND		MARYLAND MONTGOMERY	
CITY (If outside corporate limits, write RURAL and OR, give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town OR, give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Archibald</i> (Middle) <i>Sterling</i> (Last) <i>Deemer</i>		4 - 3 - 1951	
5. SEX		6. COLOR OR RACE	
M		N.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Carpenter		Carpenter	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Archibald Deemer</i>		<i>Mary Kromp</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
		214-12-7050A	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
<i>Mrs. Prad Deemer</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>462.2</i>		(a) <i>Myocarditis - chronic</i>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>93.0</i>		(b) <i>Bronchitis -</i>	
		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>None</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF INJURY)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
OF INJURY		m. At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/11</i> , 1949, to <i>4/3</i> , 1951, that I last saw the deceased alive on <i>4/11</i> , 1951, and that death occurred at <i>8:00</i> m., from the causes and on the date stated above. SIGNATURE: <i>M. B. B.</i> ADDRESS: <i>801 S. Park St. 20210</i> DATE SIGNED: <i>4/11/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>4/5/51</i>	
DATE REC'D BY LOCAL REG. <i>4-7-51</i>		NAME OF CEMETERY OR CREMATORIUM REGISTRAR'S SIGNATURE <i>Frances Patten</i>	
		LOCATION (City, town, or county) (State) <i>Montgomery Md.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Werner &amp; Pumfrey 8434 Ga. Ave., Silver Spring</i>			
		J. 51034 Maryland	

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

3966

1. PLACE OF DEATH COUNTY Montgomery County		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN TAKOMA PARK		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TAKOMA PARK, MARYLAND		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 500 JACKSON Avenue		STREET ADDRESS 500 JACKSON AVENUE (If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle)	(Last) TURNER, Jr.	
4. DATE OF DEATH April 26th, 1951	(Month)	(Day)	(Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH 3-22-1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	10b. KIND OF BUSINESS OR INDUSTRY Plumbing	11. BIRTHPLACE (State or foreign country) ORANGE, NEW JERSEY	12. CITIZEN OF WHAT COUNTRY United States	
13. FATHER'S NAME JAMES TURNER, SR.	14. MOTHER'S MAIDEN NAME MARY O'LEARY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 148 14 0684	17. INFORMANT AND ADDRESS Takoma Park, Md. MRS. LEONA BATAILLE-500 JACKSON AVENUE		
18. MEDICAL CERTIFICATION				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) Uremia Antecedent cause(s) (b) Hypertensive cardio-vascular renal disease Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 4-4-51, to 4-26-51, that I last saw the deceased alive on 4-25, 1951, and that death occurred at 7:35 A.m., from the causes and on the date stated above. SIGNATURE <i>W. Danish</i> ADDRESS <i>913 Pershing St. Silver Spring</i> DATE SIGNED <i>4-26-51</i>				
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4-30-51	NAME OF CEMETERY OR CREMATORIUM Holy Sepulchre Cemetery	LOCATION (City, town, or county) East Orange, New Jersey	(State)
DATE REC'D BY LOCAL REG. 4-26-51	REGISTRAR'S SIGNATURE <i>Frances Deller</i>	24. FUNERAL DIRECTOR <i>W. Martin</i>	ADDRESS <i>Dr. Abrahams</i>	

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BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3967

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <b>DISTRICT OF COLUMBIA</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>SILVER SPRING</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>WASHINGTON</b>	
LENGTH OF STAY (in this place) <b>26 mos.</b>		STREET ADDRESS <b>3945 Conn Ave., NW</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1508 BALLARD ST.</b>			
3. NAME OF DECEASED (Type or Print)	(First) <b>ELLA</b>	(Middle) <b>MAGRUDER</b>	(Last) <b>TURTON</b>
4. SEX <b>F</b>	5. COLOR OR RACE <b>W</b>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	7. DATE OF BIRTH <b>1864</b>
8. AGE last birthday <b>86</b>	9. IF under 1 year Months. <b>0</b>	10. IF under 24 hrs. Days <b>0</b>	11. If under 1 year Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>DISTRICT OF COLUMBIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN BOOTH TURTON</b>	14. MOTHER'S MAIDEN NAME <b>SARAH ANN RAGGLES.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>123-45-6789</b>	17. INFORMANT AND ADDRESS <b>Ruth Denham - 3945 Conn Ave (D.C.)</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause **Acute congestive heart failure**

10 days

420.0 Antecedent cause(s) **Arterio-venous heart disease**

15 yrs.

93d Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

15 yrs.

(b)

**Hypertension**

15 yrs.

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from **Sept 15, 1950**, to **April 2, 1951**, that I last saw the deceased  
alive on **April 1, 1951**, and that death occurred at **11:15 A.M.** m., from the causes and on the date stated above.  
SIGNATURE **Frances Reckless** ADDRESS **717 Clarke Ave. N.W. Wash. D.C.** DATE SIGNED **4-2-51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	DATE <b>4-5-1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>OAK HILL CEMETERY</b>	LOCATION (City, town, or county) <b>WASHINGTON, D.C.</b>	(State)
DATE REC'D BY LOCAL REG.	REG. <b>api 3/51</b>	REGISTRAR'S SIGNATURE <b>Frances Foster</b>	FUNERAL DIRECTOR <b>H. D. Dowers, Sons, Wash., D.C.</b>	ADDRESS



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. is especially important.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3968

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Bethesda		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4401 Fairfield Dr.		STREET ADDRESS 4401 Fairfield Dr. (If rural, give location)	
3. NAME OF DECEASED (Type or Print) ISABEL	(First) (Middle) WALKER	(Last) VANDERWERKER	4. DATE OF DEATH 15 April 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED (Specify) WIDOWER	8. DATE OF BIRTH 18 Aug 1862
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. School Teacher		10b. KIND OF BUSINESS OR INDUSTRY WASH., D.C. Gov't.	11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME Samuel H. Walker		12. CITIZEN OF WHAT COUNTRY? US	
15. WAS DECRASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Col. F. H. Vanderwerker 4401 Fairfield Dr. Bethesda, Md.

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 1620	(a) Acute Congestive Heart Failure	INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
Antecedent cause(s) 93d	(b) Arterio-sclerosis - (generalized)	90 yrs.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)
(STATE)						
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED White at Not White Work At work		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan., 1951, to April 15, 1951, that I last saw the deceased alive on April 15, 1951, and that death occurred at 2:30 P.m., from the causes and on the date stated above.						
SIGNATURE		(Degree or title)	ADDRESS		DATE SIGNED	

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 4/17/51	NAME OF CEMETERY OR CREMATORIAL Congressional	LOCATION (City, town, or county) Washington, D.C.	(State)
DATE REC'D BY LOCAL REG. 4-16-51	REGISTRAR'S SIGNATURE Helen L. Ehrpfelt	24. FUNERAL DIRECTOR Robert A. Humphrey	ADDRESS Bethesda, Md.	

RECEIVED  
APR 17 1951  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH. COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY	
TOWN		Bethesda		TOWN		Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		5212 Western Ave.		STREET ADDRESS		5212 Western Ave.	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)		
4. SEX		5. COLOR OR RACE	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	7. DATE OF BIRTH	8. AGE last birthday	9. If under 1 year Months	10. If under 24 hrs. Days
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	7. DATE OF BIRTH	9. AGE last birthday	10. If under 1 year Months	11. If under 24 hrs. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Housewife		own home		Virginia		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Christian Johnson		Virginia Wallace		No		17. INFORMANT	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		48 hours.					
443X Immediate cause		(a) Cerebral Hemorrhage.					
93d Antecedent cause(s)		(b) Hypertensive Heart Disease.					
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS		12 years.					
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 10</u> , 19 <u>50</u> , to <u>Mar. 1</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>7 April</u> , 19 <u>51</u> , and that death occurred at <u>6:30 P</u> m., from the causes and on the date stated above.		(Degree or title)		ADDRESS		DATE SIGNED	
SIGNATURE		ADDRESS		DATE SIGNED		<u>Mar. 1/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State)	
Burial		4-11-51		Cedar Hill		Brentwood, Md	
DATE REC'D BY LOCAL REG.		7-7-51		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
T		Helen Kurvaek		Signature		ADDRESS	
VS. A15		Co. 3901-426-37-164		Wash. D.C.			

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3970

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <b>Virginia</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Bethesda, Rural</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Arlington</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U.S. Naval Hospital</b>		STREET ADDRESS <b>567 20th Street, South,</b>	
3. NAME OF DECEASED (Type or Print) <b>Denver</b>	(First) <b>Denver</b>	(Middle) <b>Lynn</b>	(Last) <b>WILLIAMS</b>
4. DATE OF DEATH <b>April 14,</b>	(Month) <b>April</b>	(Day) <b>14</b>	(Year) <b>1951</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Apr 9, 1951</b>
9. AGE last birthday <b>00</b>	If under 1 year <b>00</b>	Months <b>00</b>	Days <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>— — —</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>
13. FATHER'S NAME <b>Lester D. WILLIAMS</b>	14. MOTHER'S MAIDEN NAME <b>Madeline Lois LINDLEY</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>— — —</b>	17. INFORMANT AND ADDRESS <b>Father: Lester D. WILLIAMS</b>	
18. MEDICAL CERTIFICATION <b>Same as item # 2</b>			
INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
770.0 Immediate cause <b>Antecedent cause(s)</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>161a</b>	(a) <b>Atelostosis complete left Pecten Rupturing 10g</b>	(b) <b>Kerinitis</b>	2 days
(c) <b>Erythromelitis Fecalis</b>			5 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? ADDRESS	
22. I hereby certify that I attended the deceased from <b>Apr 9, 1951</b> , to <b>Apr 14, 1951</b> , that I last saw the deceased alive on <b>Apr 14, 1951</b> , and that death occurred at <b>11:23 P.m.</b> , from the causes and on the date stated above. SIGNATURE <b>A. GEDAROVICH</b> (Degree or title) <b>ADDRESS</b> DATE SIGNED <b>April 16, 1951</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Apr 19, 1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	LOCATION (City, town, or county) <b>Arlington, Virginia</b>
DATE REC'D BY LOCAL <b>REG</b> <b>Apr 16, 1951</b>	REGISTRAR'S SIGNATURE <b>Elie W. Washington</b>	24. FUNERAL DIRECTOR ADDRESS <b>R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town) <u>Bethesda</u> LENGTH OF STAY (In this place) TOWN <u>Bethesda</u> <u>76 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town) <u>Clarksburg</u> LENGTH OF STAY TOWN <u>Clarksburg</u> <u>maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS <u>Bethesda Maryland</u>	
3. NAME OF DECEASED (Type or Print) <u>Clifton</u> (First) <u>Delaware</u> (Middle) <u>Wines</u> (Last)		4. DATE OF DEATH <u>April 19</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 31</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clarksburg School</u>	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) <u>Montgomery</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Emily E Wines</u>	
18. MEDICAL CERTIFICATION			

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cerebral hemorrhage and laceration  
due to bullet wound in skullINTERVAL BETWEEN  
ONSET AND DEATH

12 hrs

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the under lying cause last(b) 164c

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

Yes  No 

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office building, etc.) <u>home</u>	(CITY OR TOWN) <u>Clarksburg</u> (COUNTY) <u>Montgomery</u> (STATE) <u>md</u>
INJURY <u>TIME (Month) (Day) (Year) (Hour)</u> OF INJURY <u>4-14-51 - 5:59 p.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>self inflicted gun shot</u>

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  theron and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 21, 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>John Wesley</u>	LOCATION (City, town, or county) <u>Clarksburg</u> (State) <u>md</u>
DATE REC'D BY LOCAL REG. <u>5-1-51</u>	REG. <u>Basic m. Thompson</u>	REG. <u>Funeral Director</u>	REG. <u>Roy W Barker Gettysville</u>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3972

Reg. Dist. No. 216-213

1. PLACE OF DEATH. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>	
LENGTH OF STAY (In this place) <u>3 days</u>		STREET ADDRESS <u>4534 Avondale St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Ralph</u>		4. DATE OF DEATH <u>April 6</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 16, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Estimator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill work</u>	9. AGE last birthday 48 yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Wittler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Boehm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-03-9208</u>	
		17. INFORMANT AND ADDRESS <u>Mrs. Sara M. Wittler - 4534 Avondale St.</u>	
18. MEDICAL CERTIFICATION			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause 153XCarcinoma of Colon with metastases

1 year?

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

46e stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Cirrhosis of Liver

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) <u>Bethesda</u>	(COUNTY) <u>MONTGOMERY</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? 10:50 p.m.		

22. I hereby certify that I attended the deceased from 4-3, 1951, to 4-6, 1951, that I last saw the deceasedalive on 4-6, 1951, and that death occurred at 10:50 p.m., from the causes and on the date stated above.  
SIGNATURE Dorothy Gile, M.D. (Degree or title) ADDRESS 7011 Arlington Rd DATE SIGNED 4-7-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 10/51</u>	NAME OF CEMETERY OR CREMATORIAL <u>Western Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>4-12-51</u>	REGISTRAR'S SIGNATURE <u>Helen L. Eichenfelder</u>	24. FUNERAL DIRECTOR ADDRESS <u>Robert L. Pumfrey - Bethesda, Md.</u>		

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APR 16 1951  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Woolnough

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

3975

1. PLACE OF DEATH COUNTY MONTGOMERY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN WESTMORELAND HILLS		LENGTH OF STAY (in this place) 11 YRS.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN WESTMORELAND HILLS STREET ADDRESS 35 ELLIOTT ROAD (If rural, give location)	
3. NAME OF DECEASED (Type or Print) JOHANNA		4. DATE OF DEATH Apr 4 1951	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH OCT. 18/70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME FERDINAND DAHRT		14. MOTHER'S MAIDEN NAME HELENA STOLTZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT AND ADDRESS Miss MARIE F. WOOLNOUGH		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>31X Immediate cause (a) <u>Subacute Hemorrhage</u></p> <p>83a Antecedent cause(s) (b) <u>atherosclerosis</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 1 Year	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED Whilo at m. Not Whilo Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? ADDRESS
22. I hereby certify that I attended the deceased from <u>Sept. 15 1950 to April 4, 1951</u> , that I last saw the deceased alive on <u>Apr 4</u> , 1951, and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>John R. Dull</u> (Degree or title) ADDRESS DATE SIGNED <u>1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/9/51</u>	NAME OF CEMETERY OR CREMATORIUM <u>ALBANY RURAL CEMETERY</u>
DATE RECD BY LOCAL REG. <u>4-4-51</u>		REGISTRAR'S SIGNATURE <u>Lillian Kurzak</u>	LOCATION (City, town, or county) <u>WATERVILLE N.Y.</u>
		24. FUNERAL DIRECTOR <u>Francis J. Collins</u>	ADDRESS <u>3821-14th St. N.W. Wash. D.C.</u>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maple Lane Rest Home		STREET ADDRESS 9912 Indian Lane		
3. NAME OF DECEASED (Type or Print)	(First) EDNA	(Middle) C	(Last) WRIGHT	
4. DATE OF DEATH	4 - 19	(Month)	(Day)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Dec. 29, 1875	
9. AGE last birthday 75 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resident Manager	11. BIRTHPLACE (State or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Mathew McEwen	14. MOTHER'S MAIDEN NAME Anna Hyland	17. INFORMANT Mrs. Harold M. Morrey, 9912 Indian Lane		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 578-09-3929	18. MEDICAL CERTIFICATION Silver Spring, Md.		
19. I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  153X Immediate cause (a) <i>Carcinoma of Intestines</i> Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 46e				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (d) <i>Senility</i>				
19a. DATE OF OPERATION <i>None</i>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE <i>None</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Mar. 11, 1950</i> , to <i>April 19, 1951</i> , that I last saw the deceased alive on <i>April 19, 1951</i> , and that death occurred at <i>12:18 P.m.</i> , from the causes and on the date stated above. SIGNATURE <i>Henry Lowden M.D.</i> ADDRESS <i>1603 19th St. N.W.</i> DATE SIGNED <i>4-19-51</i> (Degree or title)				
23. BURIAL, CREMATION REMOVAL (Specify) Cremation	DATE THEREOF 4/19/51	NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory	LOCATION (City, town, or county) Prince Geo. County	(State) Md.
DATE REC'D BY LOCAL REG.	REG. DATE <i>Apr. 20, 1951</i>	REGISTRAR'S SIGNATURE <i>Frances Gitter</i>	24. FUNERAL DIRECTOR ADDRESS <i>Werner E. Humphrey 8434 Ga. Ave., Silver Spring</i>	

RECEIVED

APR 24 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i> COUNTY <i>District of Columbia</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Takoma Park</i>		LENGTH OF STAY (in this place) <i>1 mon. 9 days</i>	
TOWN <i>Takoma Park</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chewy Chase</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Sanitarium Hospital</i>		STREET ADDRESS <i>3929 Morrison St. N. W.</i>	
3. NAME OF DECEASED (First) <i>Rose</i> (Middle) <i>DALE</i>		4. DATE OF DEATH (Month) <i>April</i> (Day) <i>3</i> (Year) <i>1957</i>	
5. SEX <i>Female</i>		6. COLOR OF RACE <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>9-9-71</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		9. AGE last birthday <i>79</i> yrs. If under 1 year Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Fairview West Virginia</i>	
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>Joseph Yost</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Neptune</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
(If yes, give war or date of service)		17. INFORMANT AND ADDRESS <i>Ernest L. Yost (son)</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>572.1</i>		a. <i>Unrecticulitis c Hemorrhage</i>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>123</i>		b. <i>3 weeks</i>	
c.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
OF INJURY m.		HOW DID INJURY OCCUR? ADDRESS	
22. I hereby certify that I attended the deceased from <i>14 Mar. 1951</i> , to <i>3 April 1951</i> , that I last saw the deceased alive on <i>1 April 1951</i> , and that death occurred at <i>6:45 P.m.</i> , from the causes and on the date stated above. SIGNATURE <i>Edward L. Wilson</i> (Degree or title) <i>24</i> ADDRESS <i>1801 Eye St N.W. Wash. D.C.</i> DATE SIGNED <i>4-5-51</i>			
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF <i>4-4-51</i> NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Cemetery</i> LOCATION (City, town, or county) <i>Towson</i> (State) <i>Md.</i>	
DATE RECD BY LOCAL REG. <i>4-3-51</i>		24. FUNERAL DIRECTOR REG. <i>John Dodd</i> ADDRESS <i>2901 18th St. N.W. Washington D.C.</i>	

